MEDICAID WAIVER FOR OLDER ADULTS (WOA) PROGRAM

Billing and Reimbursement Reference Guide

April 2011

Table of Contents

WAIVER FOR OLDER ADULTS (WOA) PROGRAM

Billing and Reimbursement Reference Guide

Thank you for your participation as a provider in the Medicaid Waiver for Older Adults (WOA). These billing instructions are for the services covered under the Waiver for Older Adult and are intended to assist you to accurately prepare your claims for timely and accurate payments.

The Waiver program is governed by COMAR 10.09.54 (name the Comar citation)and by the federally approved waver application. The Maryland Department of Health and Mental Hygiene (DHMH) is the State's lead agency for the Medicaid Program. Included among DHMH's responsibilities are enrolling waiver providers and processing and paying provider claims for waiver services. DHMH has delegated to the Maryland Department of Aging (MDoA) the responsibility for administering the waiver program through the Area Agencies on Aging (AAAs). Contact information for the AAAs can be found in Appendix E of these instructions.

General billing inquiries may be directed to Provider Relations, DHMH at 410-767-5503, or MDoA at 767 – 1118.

HOW IS A PROVIDER ASSIGNED A WAIVER PARTICIPANT?

- Requests for services will come from Area Agencies on Aging Case Managers based upon the participant assessed needs. Case Manager provides participants with a list of approved providers, generated by the Maryland Department of Aging (MDoA). The selected provider will be notified by the Case Manager;
- A copy of the participant's plan of care and pre-authorization forms if required will be forwarded to the selected provider. Services shout not be rendered without an approved POC.

WHAT SHOULD I BE AWARE OF AS A PROVIDER?

- The recipient must be **enrolled** in the Waiver for Older Adults program as of the date of service.
- The **provider must** be **enrolled** and **approved** as a Medicaid Waiver provider of the **specific type** of service to be provided; authorized procedure codes identified in a letter from the Department of Health and Mental Hygiene (DHMH).
- Before rendering waiver services , the provider should contact the Area Agency of Aging for the participant, to confirm that the individual is enrolled in the Waiver for Older Adults and that the provider is approved in the recipient's' plan of care to render the waiver service. A recipient's Medicaid eligibility should be verified prior to beginning service by calling the **Eligibility Verification System (EVS) at 410-333-3020 or 1- 800-492-2134**, 24 hours a day, 7 days a week. You must have the individual's Medicaid identification number.
- The waiver services must be rendered in accordance with the waiver participant's approved plan of care, COMAR 10.09.54, the State's waiver proposal, and any other applicable government requirements.
- The services must not exceed limitations or restrictions specified in the recipient's waiver plan of care or COMAR 10.09.54.
- Services covered by Medicaid (State Plan), Medicare, or another third party health insurance carrier are not reimbursable under the Medicaid Waiver for Older Adults. However, if the participant is enrolled in Medicaid, and is unable to pay the deductibles or co-pays associated with Medicare, (due to income limits), Medicaid will pay those co-payment(s) or deductible(s).
- To avoid later corrections or delays in payment, providers should check the accuracy of the information on the claim form before submission, particularly the provider's Medicaid number, the recipient's Medicaid number and billing codes. Note that claims forms must have original signatures and that Medicaid does not pay for services in advance.
- Providers are paid the lesser of their usual and customary charges to the general public, or the program rate established according to the methodology specified in COMAR 10.09.54.33 C..(3) – (18). Rate changes if any go into effect July 1 of each year and are communicated to providers by way of DHMH Transmittal.
- The program may not reimburse claims received for payment more than 12 months after the date of service. (Refer to DHMH Maryland Medical Assistance Program, General Provider Transmittal No. 71 for more details on this policy).

WHAT TYPE OF SERVICES ARE COVERED?

The following service types are covered under the Waiver:

Service Type	Procedure Codes for Billing Purposes
Assistive Devices	(W0214)
Assisted Living Services	(W0226, W0228, W0227 and W0229)
Behavioral Consultation Services	(W1724)
Dietician and Nutrition Services	(W0212)
Environmental Assessments	(W1725)
Environmental Accessibility Adaptations	(W0207)
Family or Consumer training	(W0208)
Home-delivered Meals	(W0211)
Personal Care (including Nurse Monitoring)	(W0200, W0201, W0202, W0203, and W0204)
Personal Emergency Response Systems	(W0209 and W0210)
Respite Care	(W0205, W0206, W0220, and W0221)
Senior Center Plus	(W1723)

WHERE DO I SEND COMPLETED CLAIM FORMS?

Claims for Waiver services should be submitted to the following address, unless you are otherwise notified by your local Area Agency on Aging:

ATTN: Waiver Billing
Maryland Department of Aging
301 W. Preston St., Suite 1007
Baltimore, Maryland, 21201

Please Note: a. Any Waiver billing forms for these services mistakenly sent to DHMH will be denied for payment. The claims will have to be re-done and re-submitted by the provider to the correct address, causing substantial delays in payment.

b. Claims containing errors or missing required information will be returned to the provider. The provider will be required to properly claim form and resubmit. Here are some common errors seen on claims. Claims with any of theses errors will be returned:

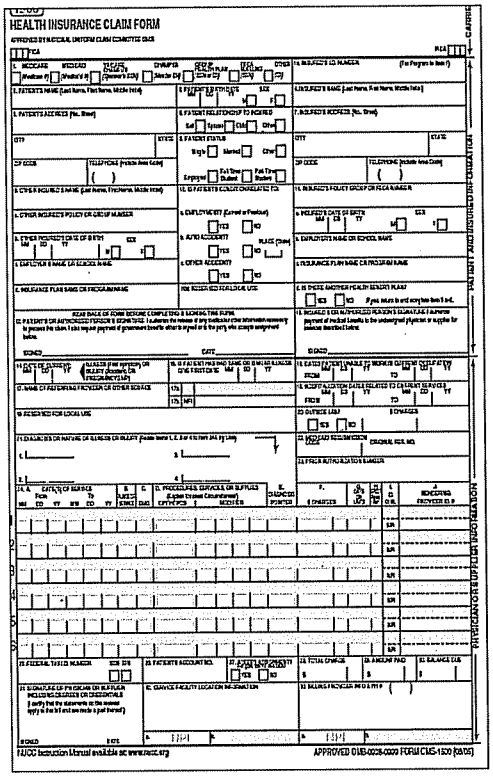
Missing Provider Number (10 digit number beginning with 5)
Missing Recipient Medicaid Number (11 digit number)
Missing or incorrect rate
Missing Procedure Code
Missing Date of Service
Missing Units of Service
Missing Place of Service Code (33 for recipient's in Assisted Living; 12 for recipients receiving service at home)

b. For providers of services requiring preauthorization, a signed preauthorization form must be obtained from the recipient's case manager. The preauthorization form must be attached to the claim form when the claim is submitted for payment. The Waiver services requiring preauthorization forms are:

Environmental Accessibility Adaptation (W0207)
Assistive Devices and Equipment (W0214)

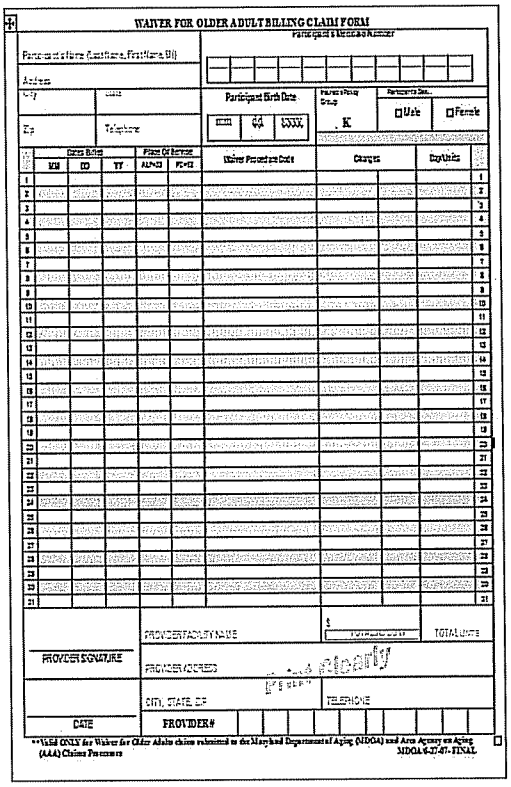
Medicaid Waiver Claim Forms

1500 Claim Form


HEALTH INSURANCE CLAIM FORM

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

MDoA Modified Billing Form*


WAIVER FOR OLDER ADULT BILLING CLAIM FORM

Copies of these forms are available for downloading from the Maryland Department of Aging website:
http://www.mdoa.state.md.us/housing.html#Medicaidhome

*MDoA will accept both types of claim forms. The Modified Billing Form is ONLY for paper claims submitted to MDoA or one of the six AAAs that process claims. DHMH will not process claims submitted on this form.

Specific Billing Instructions for Each Waiver Service

Assistive Devices and Equipment

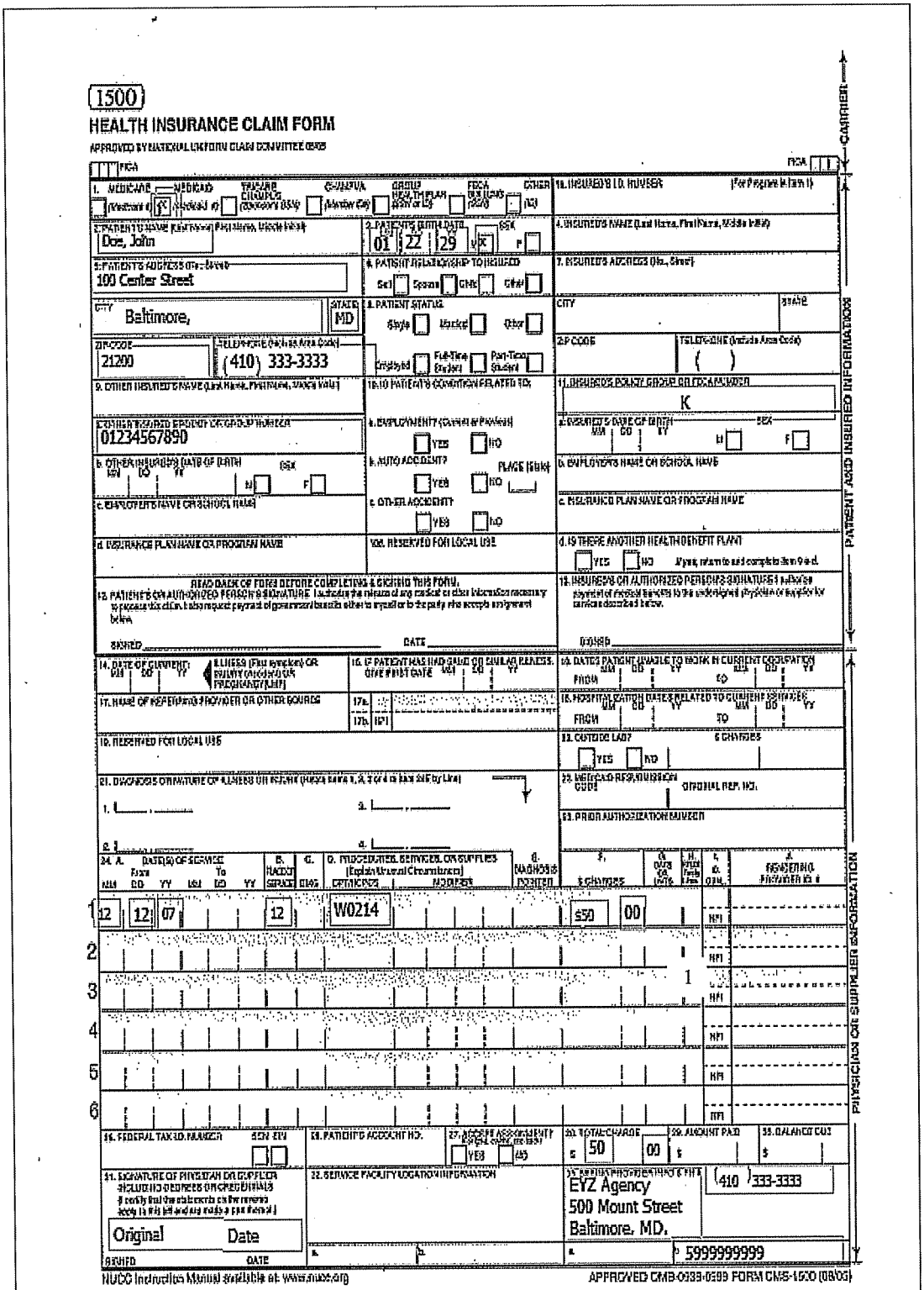
Procedure Code	Services	Unit of Service	*Rate per Unit
W0214	Assistive Devices and Equipment	Single item	Cost of item (must have preauthorization)

The following are specific instructions for billing Assistive Devices And Equipment under the Waiver for Older Adults:

- Providers must be approved to provide Assistive Devices and Equipment Services under the Medicaid Waiver for Older Adults.
- A "unit of service" is defined as one item.
- Assistive Device or Equipment must be pre-authorized and documented in the participant's plan of care. Note: Items covered under their Medicaid State Plan Disposable Medical Supplies and Durable Medical Equipment Program (DMS/DME) must be billed to that program using their assigned State Plan Medicaid number. If you have questions, please contact DHMH's Division of Community Support Services (DCSS) at 410-767-1739. DCSS may require further information to determine if the item is covered under the DMS/DME program
- Requests for reimbursement must include a copy of the pre-authorization form and either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED.
- Assistive device and equipment must meet applicable standards of manufacturer, design, and installation.
- See COMAR 10.09.54.29 and DHMH Waiver Transmittal # 23 for additional information on this service.

Note: Waiver payments for assistive devices and equipment are capped at $1,000 per participant over a 12-month period based on a calendar year (i.e. Assistive Device or Equipment provided 1/1/07; next eligibility date would be 1/02/08). **Exclusions include:** Eyeglasses, hearing aids and dentures.

Sample Claim for Assisted Devices and Equipment



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (ID/DoD #) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 | SEX: M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Baltimore, | STATE: MD

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 21200 | TELEPHONE (Include Area Code): (410) 333-3333

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
K

a. OTHER INSURED'S POLICY OR GROUP NUMBER
01234567890

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH | SEX

b. OTHER INSURED'S DATE OF BIRTH | SEX

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM | TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L _____ 3. L _____

2. L _____ 4. L _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12	12 07	12		W0214		1	50 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ 50 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #
EYZ Agency
500 Mount Street
Baltimore, MD.
(410) 333-3333

a. | b. 5999999999

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Assisted Living Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0226	Assistive Living Level II – no medical day care	Daily	$55.71 per day
W0228	Assistive Living Level II – with medical day care	Daily	$41.80 per day
W0227	Assistive Living Level III – no medical day care	Daily	$70.29 per day
W0229	Assistive Living Level III – with medical day care	Daily	$52.70 per day

Following are specific instructions for billing Assisted Living Services under the Waiver for Older Adults:

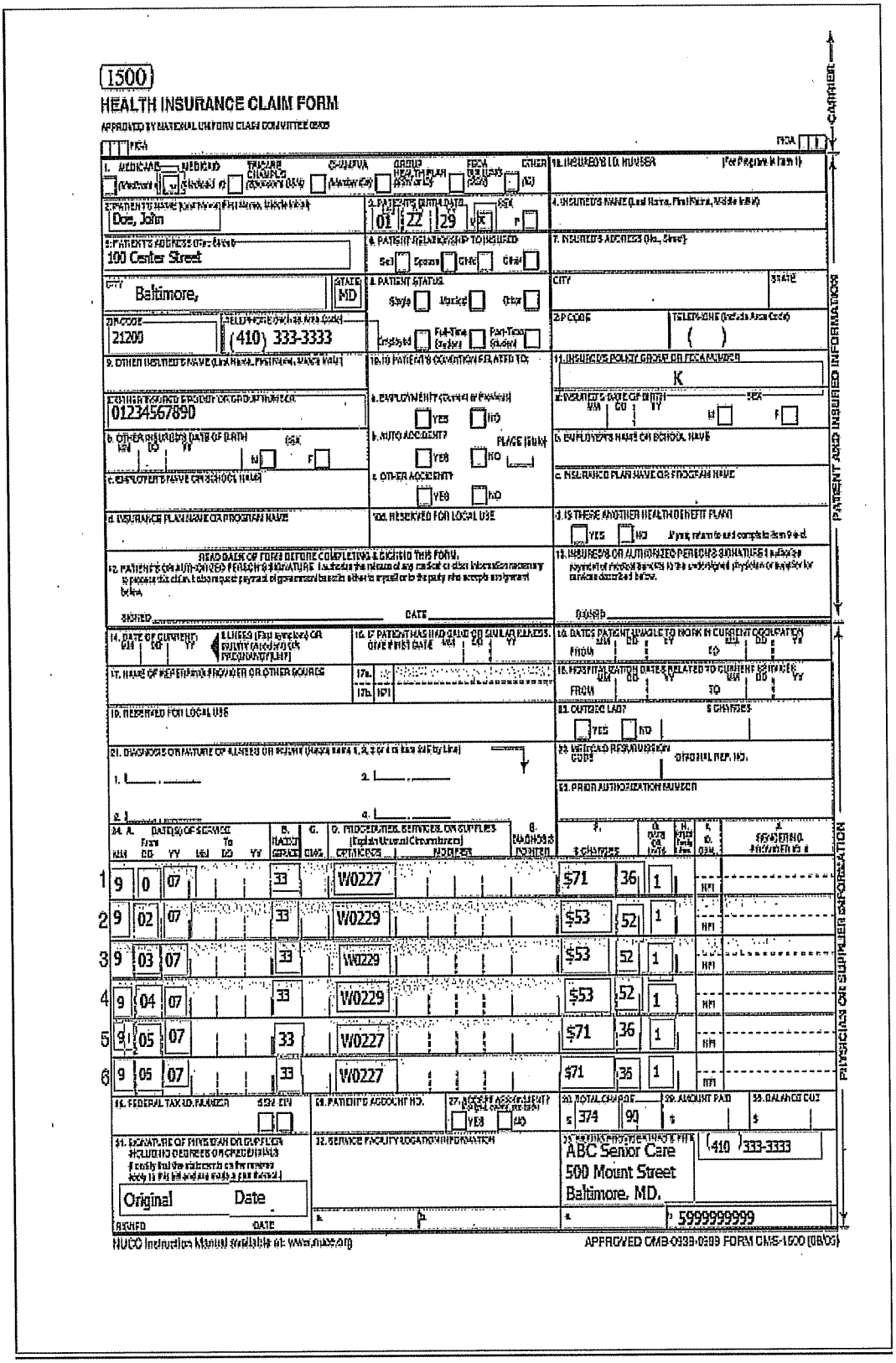
- Providers must be approved to provide Assisted Living Services under the Medicaid Waiver for Older Adults
- A "unit of service" for assisted living services is defined as one day
- Specific services to be provided are identified in COMAR 10.09.54.16.B(1 – 11)
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED The place of service for AL is code "33" meaning at ALF
- Daily rates are based on the participant's level of care and attendance at Adult Medical Care with pre-authorization.
- The service and provider must be identified in the participant's approved Plan of Care. A copy of the participant's plan of care must be kept on file
- Assisted living charges paid by the Medicaid Waiver do **not** include room and board. The waiver participant is expected to pay the provider's charge for room and board, which may not exceed $420 per month for a waiver participant. In addition, Waiver rules require that a participant with income over a certain level must make monthly payments toward the cost of their assisted living services. The monthly amount that must be paid to the ALF provider by the participant is called the "contribution to care" (CTC). The amount Medicaid pays the ALF provider is reduced by the amount of the participant's monthly CTC. The monthly CTC amount paid to the provider by the participant is in addition to the amount (up to $420 a month) a participant must pay for room and board. See Waiver Transmittal #21 for additional information on CTC.
- The provider may not bill for any days during the month that the participant was not eligible for the waiver or was not considered to be residing in the facility because the participant:
  - moved out of the provider's facility;
  - Had not yet moved into the provider's facility;
  - was an inpatient for one or more nights at a hospital, nursing facility, or other medical institution; or
  - was absent from the provider's facility for more than seven (7) nights during a calendar month at the participant's choice for personal reasons, (i.e., family visit or vacation).
- Claims may only be submitted after the end of the month of service.

Note: As part of the provider agreement, an assisted living facility agrees to accept the combination of funds paid by Medicaid and the participant (room and board + CTC) as **payment in full**.

IMPORTANT

ASSISTED LIVING SERVICE PROVIDERS THAT DIRECTLY BILL DHMH MUST USE THE CMS 1500 CLAIM FORM (Appendix D). USE OF OTHER CLAIM FORMS WILL RESULT IN REJECTION OF CLAIMS.

Sample Claim for Assisted Living Services Level III with 3 Day of Medical Day Care Per Week



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX
Doe, John	01 ZZ 29 M X F
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED
100 Center Street	Self Spouse Child Other
CITY: Baltimore,	STATE: MD
8. PATIENT STATUS	Single Married Other
ZIP CODE: 21209	TELEPHONE (Include Area Code): (410) 333-3333
	Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	K
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
01234567890	a. INSURED'S DATE OF BIRTH SEX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State) YES NO
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO
c. EMPLOYER'S NAME OR SCHOOL NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	FROM TO
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. _____ 2. _____ 3. _____ 4. _____	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 9 0 07		33		W0227			$71	36	1	NPI	
2 9 02 07		33		W0229			$53	52	1	NPI	
3 9 03 07		33		W0229			$53	52	1	NPI	
4 9 04 07		33		W0229			$53	52	1	NPI	
5 9 05 07		33		W0227			$71	36	1	NPI	
6 9 05 07		33		W0227			$71	36	1	NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 374 90	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

ABC Senior Care
500 Mount Street
Baltimore, MD.

(410) 333-3333

a. 5999999999

CARRIER

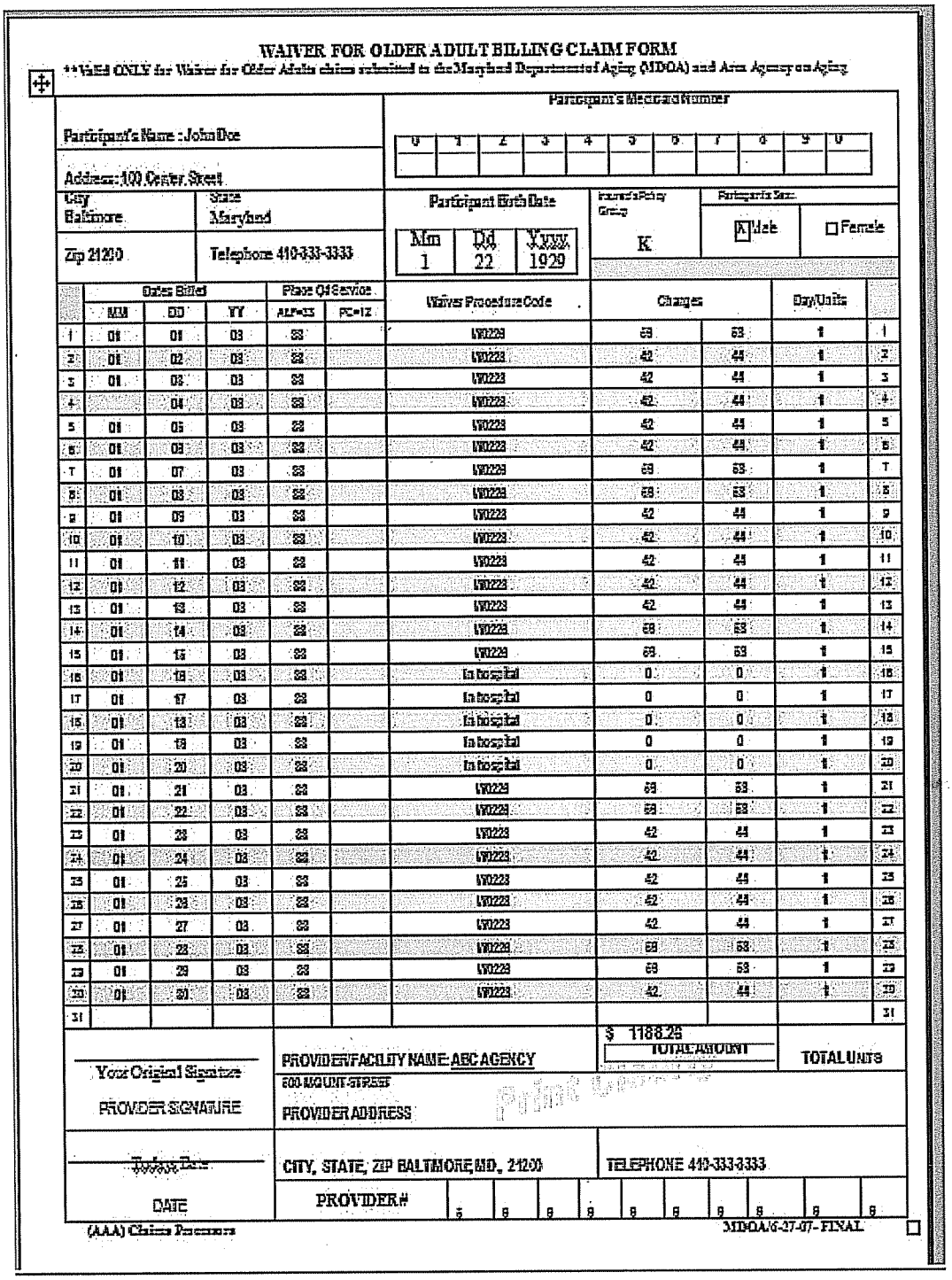
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Sample Claim for Assisted Living Level II with 5 Days of Medical Day Care Per Week



WAIVER FOR OLDER ADULT BILLING CLAIM FORM

**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging

Participant's Name : John Doe

Participant's Medicaid Number: 0 1 2 3 4 5 6 7 8 9 0

Address: 100 Center Street

City: Baltimore | State: Maryland

Zip: 21200 | Telephone: 410-333-3333

Participant Birth Date: Mm 1 | Dd 22 | Yyyy 1929

Insured's Policy Group: K

Participant's Sex: [X] Male [ ] Female

	Dates Billed MM	DD	YY	Place Of Service ALF=13	PC=12	Waiver Procedure Code	Charges		Day/Units	
1	01	01	03	33		W0229	88	88	1	1
2	01	02	03	33		W0223	42	44	1	2
3	01	03	03	33		W0223	42	44	1	3
4		04	03	33		W0223	42	44	1	4
5	01	05	03	33		W0223	42	44	1	5
6	01	06	03	33		W0223	42	44	1	6
7	01	07	03	33		W0229	88	88	1	7
8	01	08	03	33		W0229	88	88	1	8
9	01	09	03	33		W0223	42	44	1	9
10	01	10	03	33		W0223	42	44	1	10
11	01	11	03	33		W0223	42	44	1	11
12	01	12	03	33		W0223	42	44	1	12
13	01	13	03	33		W0223	42	44	1	13
14	01	14	03	33		W0229	88	88	1	14
15	01	15	03	33		W0229	88	88	1	15
16	01	16	03	33		In hospital	0	0	1	16
17	01	17	03	33		In hospital	0	0	1	17
18	01	18	03	33		In hospital	0	0	1	18
19	01	19	03	33		In hospital	0	0	1	19
20	01	20	03	33		In hospital	0	0	1	20
21	01	21	03	33		W0229	88	88	1	21
22	01	22	03	33		W0229	88	88	1	22
23	01	23	03	33		W0223	42	44	1	23
24	01	24	03	33		W0223	42	44	1	24
25	01	25	03	33		W0223	42	44	1	25
26	01	26	03	33		W0223	42	44	1	26
27	01	27	03	33		W0223	42	44	1	27
28	01	28	03	33		W0229	88	88	1	28
29	01	29	03	33		W0229	88	88	1	29
30	01	30	03	33		W0223	42	44	1	30
31										31

$ 1188.28 TOTAL AMOUNT | TOTAL UNITS

Your Original Signature
PROVIDER SIGNATURE

PROVIDER/FACILITY NAME: ABC AGENCY
600 MOUNT STREET
PROVIDER ADDRESS

Today's Date
DATE

CITY, STATE, ZIP: BALTIMORE, MD., 21200
TELEPHONE: 410-333-3333

PROVIDER #: 5 8 8 8 8 8 8 8 8 8

(AAA) Claims Processor

MDOA/6-27-07- FINAL

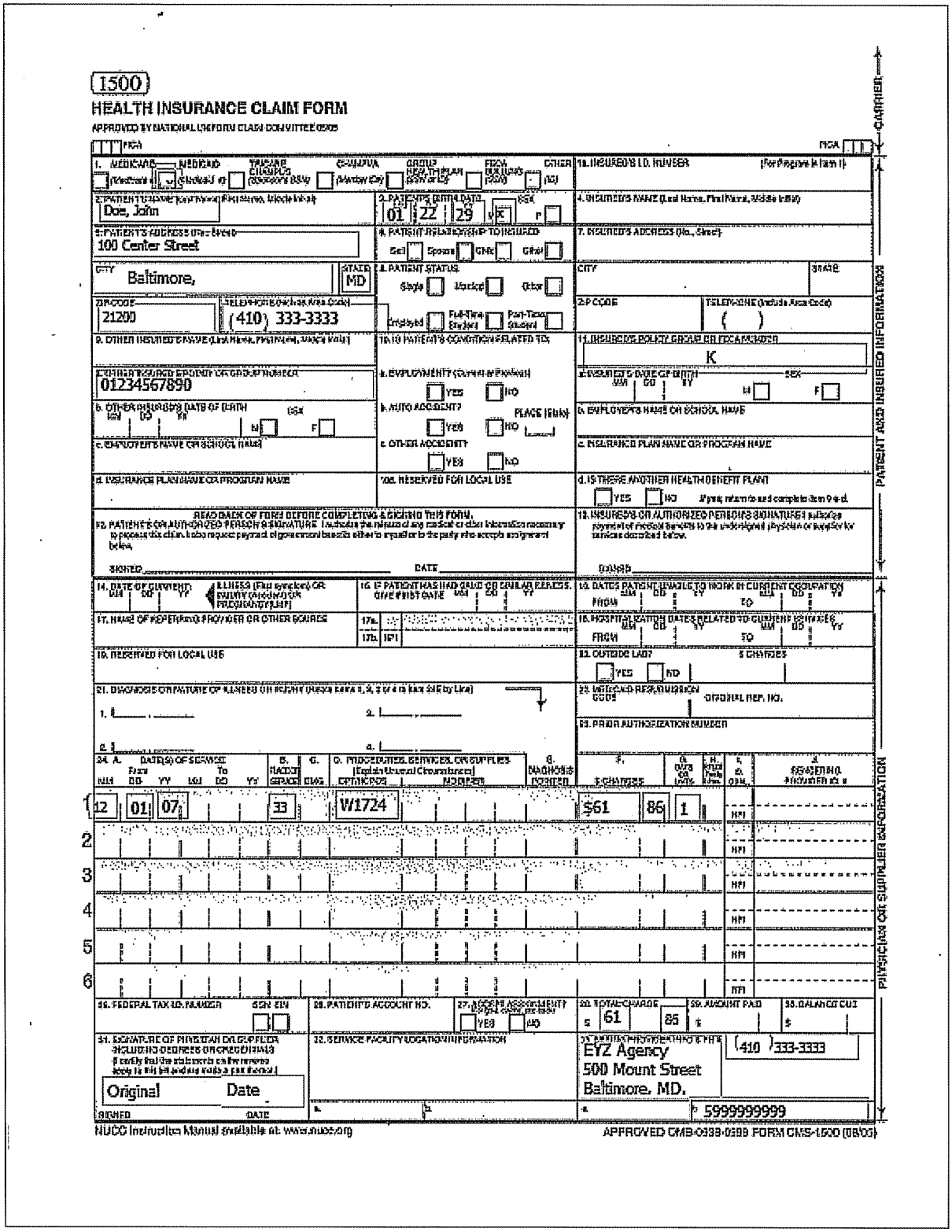
Behavior Consultation Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W1724	Behavior Consultation	1 hour	$60.93 per hour

Following are specific instructions for billing Behavior Consultation services under the Waiver for Older Adults.

- Providers must be approved to provide Behavior Consultation Services under the Medicaid Waiver for Older Adults.
- The service and provider must be identified in the participant's approved Plan of Care
- A "unit of service" is one hour (no partial hour increments are accepted)
- Services may be provided to waiver participants residing either at home or in an assisted living facility.
- The provider must:
  - respond within 24 hours after receiving a referral
  - evaluate the waiver participant's acute behavior change, assess the situation, determine the contributing factors, and recommend interventions and treatments;
  - Verbally review the report with the Case Manager (CM) and either the family or assisted living provider to discuss the report's findings and recommendations and a course of action, including any related needed medical interventions.
  - Submit a written report to the case manager and to either the family or assisted living provider, which assesses the situation and makes recommendations
  - Claims are to be submitted for services rendered by a qualified individual during a home visit and not for time spent on related activities before or after the visit . See COMAR 10.09.54.20 for additional information on reimbursement for this service. .
  - Medicaid will pay the provider the lesser of 62.17 per unit of service or the provider's usual and customary charge for the general public.
  - Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim For Behavior Consultation



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 SEX: M / F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Baltimore, | STATE: MD

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 21200 | TELEPHONE (Include Area Code): (410) 333-3333

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (Current or Previous): YES / NO

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M / F

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY | SEX: M / F

b. AUTO ACCIDENT? YES / NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES / NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L _____ 2. L _____

3. L _____ 4. L _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 01 07		33		W1724		$61	86	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: SSN / EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO

28. TOTAL CHARGE: $ 61 85

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

EYZ Agency
500 Mount Street
Baltimore, MD.

(410) 333-3333

a. b. 5999999999

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

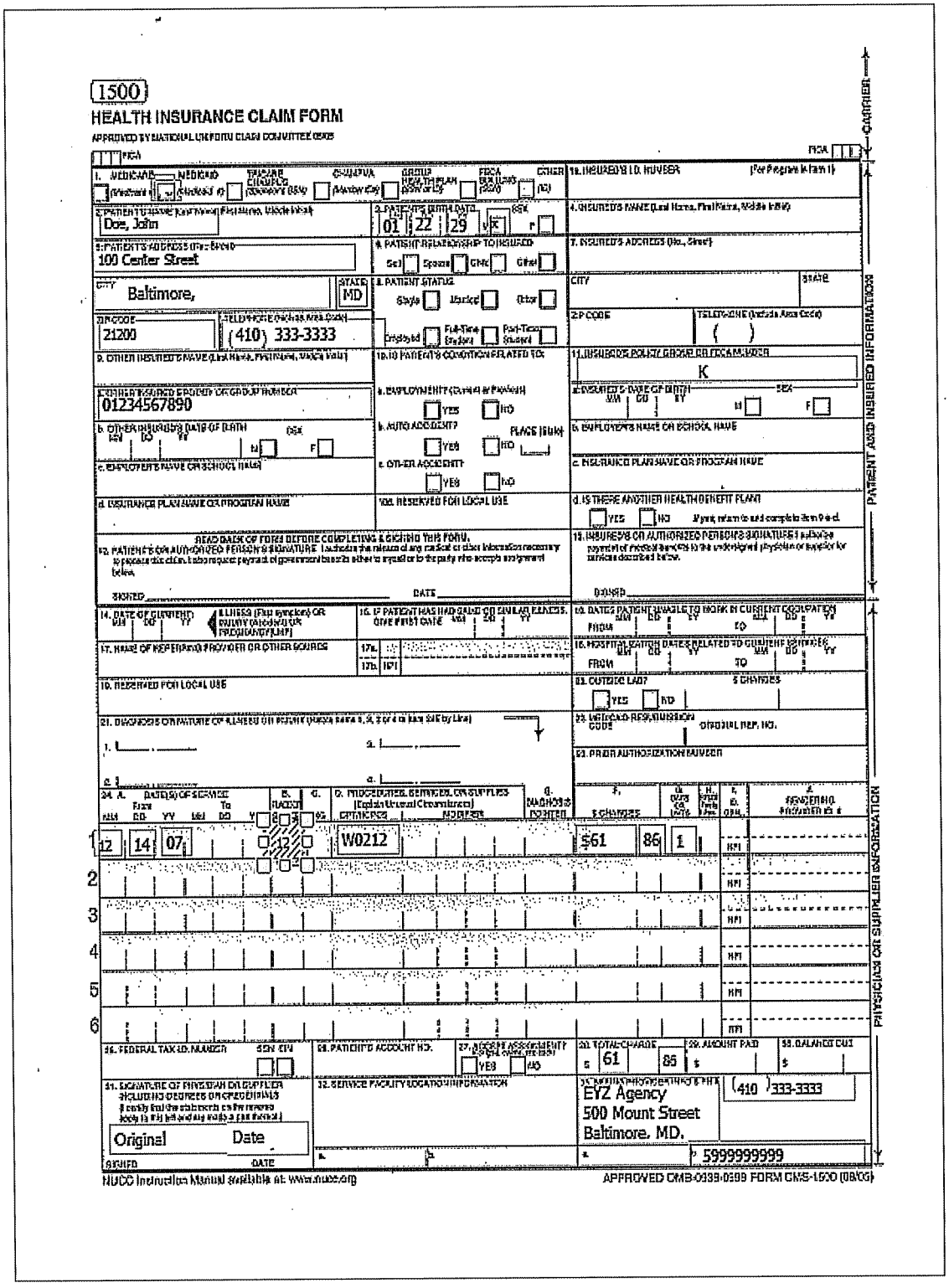
Dietitian and Nutritionist Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0212	Dietitian or Nutritionist Service	1 hour	$60.93 per hour

Following are specific instructions for billing Dietitian or Nutritionist Services under the Waiver for Older

- Adults Providers must be approved to provide Dietitian and Nutritionist Services under the Medicaid Waiver for Older Adults
- A "unit of service" for Dietitian and Nutritionist Services is one hour of covered services provided during or in conjunction with a home visit with the waiver participant.
- This service and provider must be listed in the participant's approved Plan of Care
- Services must be:
  - Delivered one-on-one, and may not be rendered on a group basis or in a classroom setting.
  - Provided to in-home participants only
- Other third party insurances should be billed prior to billing the Medicaid Waiver.
- See COMAR 10.09.54.28 for additional information on reimbursement for this service
- Medicaid will pay the provider the lesser of: $62.17per unit of service or the provider's usual and customary charge
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Dietitian and Nutrition Services



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John	3. PATIENT'S BIRTH DATE: 01 22 29 SEX: M
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street): 100 Center Street	6. PATIENT RELATIONSHIP TO INSURED: Self
7. INSURED'S ADDRESS (No., Street)	
CITY: Baltimore,	STATE: MD
8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY / STATE
ZIP CODE: 21200	TELEPHONE (Include Area Code): (410) 333-3333
ZIP CODE / TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: K	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890	a. EMPLOYMENT? (Current or Previous): YES / NO
a. INSURED'S DATE OF BIRTH / SEX	
b. OTHER INSURED'S DATE OF BIRTH / SEX	b. AUTO ACCIDENT? YES / NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM _____ TO _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM _____ TO _____	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. _____ 2. _____ 3. _____ 4. _____	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 14 07				W0212			$61	86	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE: $ 61 86	29. AMOUNT PAID: $	30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Original Date	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #: EYZ Agency 500 Mount Street Baltimore, MD.	(410) 333-3333	
SIGNED DATE	a.		b. 5999999999		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

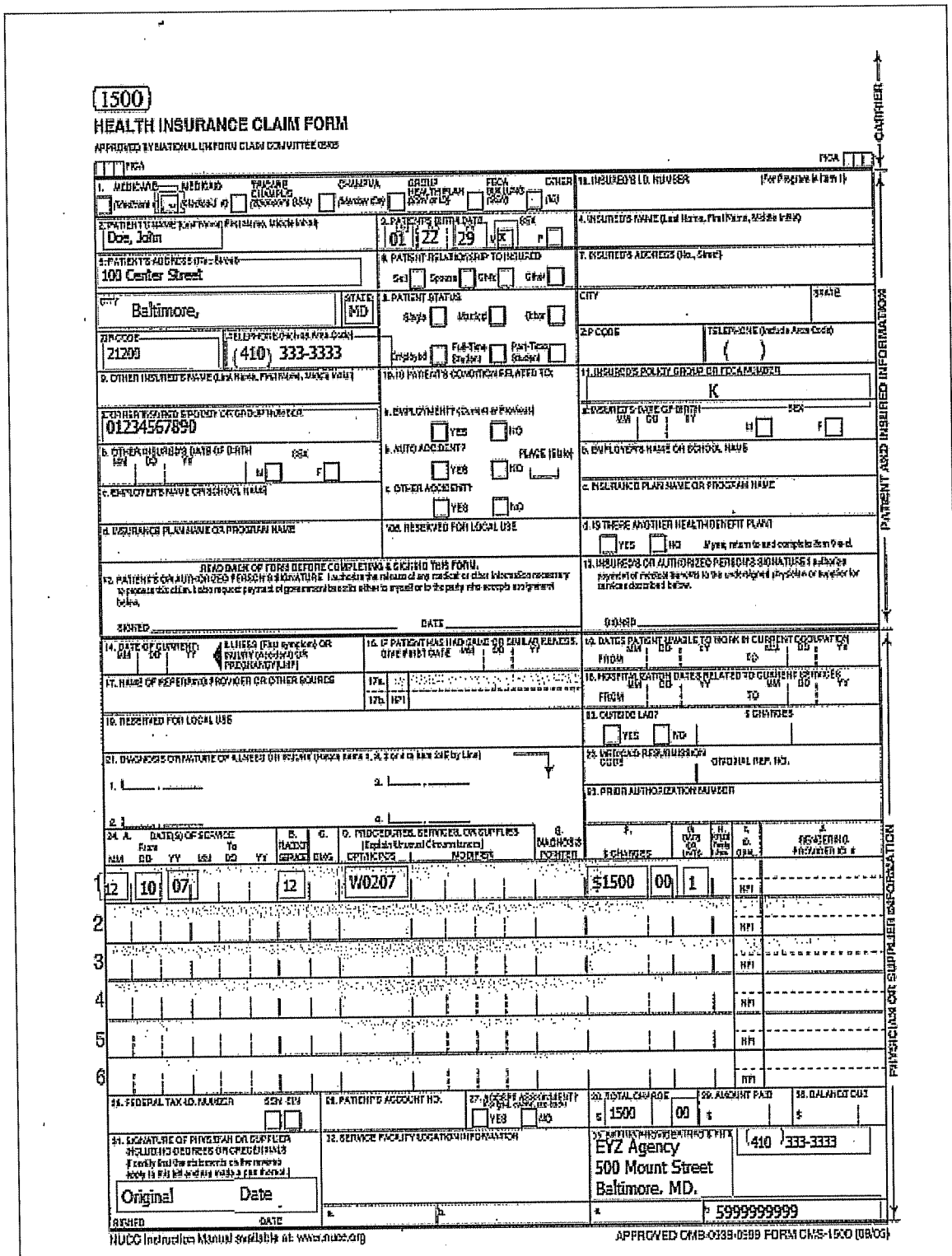
Environmental Accessibility Adaptations

Procedure Code	Services	Unit of Service	*Rate per Unit
W0207	Environmental Accessibility Adaptations	One or more physical adaptations to a participant's home	Based on bid – not to exceed $5,000 per year or $10,000 in the participants lifetime

Following are specific instructions for billing Environmental Accessibility Adaptations under the Waiver for Older Adults:

- Providers must be approved to provide Environmental Accessibility Adaptations Services under the Medicaid Waiver for Older Adults
- A "unit of service" is defined as one or more physical adaptations to the waiver participant's residence, completed as one job.
- This service and provider must be listed in the participant's approved Plan of Care. In addition, a Pre-authorization Form completed by participant's CM is required.
- Services must be preauthorized and receive final approval from the Case Manager as well as the owner of the home or building (when the owner is not the waiver participant) prior to starting the adaptations.
- Work must be performed in accordance with State and local building codes; and the appropriate inspections, permits, and approvals must be obtained. See COMAR 10.09.54.08 & .24 and DHMH Waiver Transmittal # 23 for additional information on reimbursement for this service.
- Requests for reimbursement must include a copy of the pre-authorization form and either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED.

Sample Claim for Environmental Accessibility Adaptations



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME: Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 SEX: M

4. INSURED'S NAME

5. PATIENT'S ADDRESS: 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self

7. INSURED'S ADDRESS

CITY: Baltimore,

STATE: MD

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

ZIP CODE: 21200

TELEPHONE: (410) 333-3333

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES / NO

a. INSURED'S DATE OF BIRTH / SEX

b. OTHER INSURED'S DATE OF BIRTH / SEX

b. AUTO ACCIDENT? YES / NO PLACE (STATE)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES / NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM _____ TO _____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM _____ TO _____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 2. _____

3. _____ 4. _____

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 10 07		12		W0207			$1500	00	1	NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN / EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO

28. TOTAL CHARGE: $ 1500 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #: EYZ Agency 500 Mount Street Baltimore, MD. (410) 333-3333

a. 5999999999 b.

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Environmental Assessments

Procedure Code	Services	Unit of Service	*Rate per Unit
W1725	Environmental Assessment	An assessment	The lesser of $387.68 per unit or the provider's usual and customary charge.

Following are specific instructions for billing for Environmental Assessment services under the Waiver for Older Adults.

- Providers must be approved to provide Environmental Assessment services under the Medicaid Waiver for Older Adults
- A "unit of service" is a completed Environmental Assessment on a form approved by the Program
- This service and provider must be listed in the participant's approved Plan of Care.
- The services must be rendered by a licensed occupational therapist.
- Services may be provided to waiver participants residing either at home or in an assisted living facility
- Medicaid will pay the provider the lesser of: $395.59 per unit of service or the provider's usual and customary charges, reduced for any payments by Medicare or another insurer.
- Other third party insurances should be billed prior to billing the Medicaid Waiver.
- See COMAR 10.09.54.19 for additional information on reimbursement for this service.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Environmental Assessment

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (ID/DoD #)	CHAMPVA (Member ID#)
GROUP HEALTH PLAN (ID# or SSN)	FECA BLK LUNG (ID)	OTHER (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Doe, John		
3. PATIENT'S BIRTH DATE	01 22 29	SEX M	F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)	100 Center Street		
6. PATIENT RELATIONSHIP TO INSURED	Self	Spouse	Child	Other
7. INSURED'S ADDRESS (No., Street)			
CITY	Baltimore,	STATE	MD
8. PATIENT STATUS	Single	Married	Other
CITY		STATE	
ZIP CODE	21200	TELEPHONE (Include Area Code)	(410) 333-3333
ZIP CODE		TELEPHONE (Include Area Code)	( )
	Employed	Full-Time Student	Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
10. IS PATIENT'S CONDITION RELATED TO:			
11. INSURED'S POLICY GROUP OR FECA NUMBER	K		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	01234567890		
a. EMPLOYMENT? (Current or Previous)	YES	NO	
a. INSURED'S DATE OF BIRTH	MM DD YY	SEX M	F
b. OTHER INSURED'S DATE OF BIRTH	MM DD YY	SEX M	F
b. AUTO ACCIDENT?	YES	NO	PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME			
c. OTHER ACCIDENT?	YES	NO	
c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME			
10d. RESERVED FOR LOCAL USE			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES	NO	If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
		17b. NPI	
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. L _____ 2. L _____ 3. L _____ 4. L _____			23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 10 07		33		W1725			$393	65	1	NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES	NO	28. TOTAL CHARGE $ 393 65
29. AMOUNT PAID $		30. BALANCE DUE $			

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (410) 333-3333

EYZ Agency
500 Mount Street
Baltimore, MD.

a. b. 5999999999

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

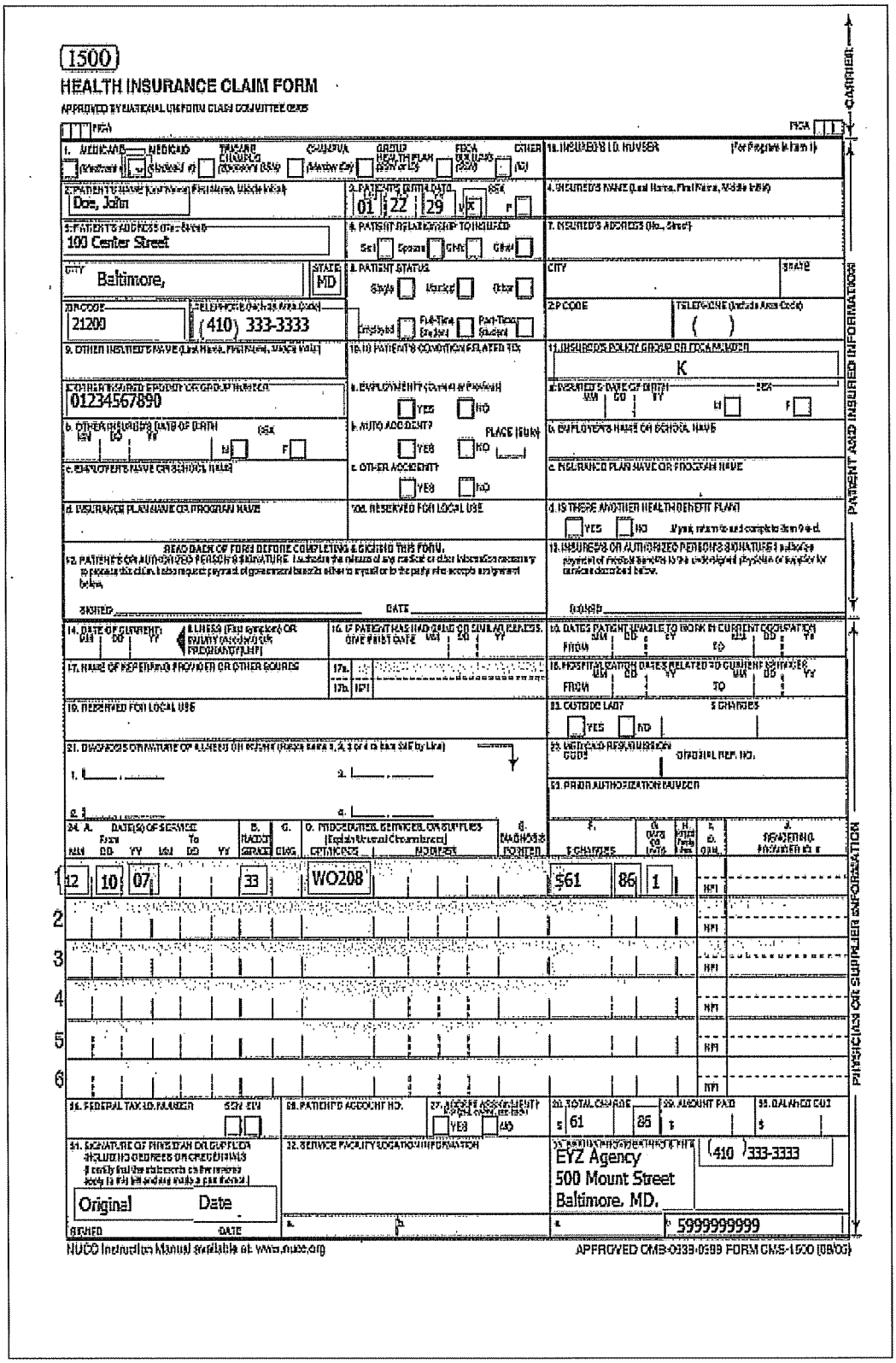
Family or Consumer Training

Procedure Code	Services	Unit of Service	*Rate per Unit
W0208	Family or Consumer Training	One Hour	$ 60.93 per hour

Following are specific instructions for billing Family or Consumer Training services under the Waiver for Older Adults:

- Providers must be approved to provide Family or Consumer Training services under the Medicaid Waiver for Older Adults
- A "unit of service" for family or consumer training is an hour of service rendered:
  1. by one of the following: licensed occupational therapist, physical therapist, registered nurse, or social worker,
  2. one-on-one during a home or office-visit with the waiver participant and/or family member.
- The topics covered by the training and counseling services must be specified in the waiver participant's approved Plan of Care and must be targeted to the individualized needs of the participant or family member receiving the training, as related to the participant's needs.
- The training may not be rendered on a group basis or in a classroom setting.
- The provider may only bill for the length of the visit. Related activities performed before or after the visit (such as planning, preparing, setting up the training, and/or following up after the training) are not covered.
- See COMAR 10.09.54.26 for additional information on reimbursement for this service.
- Medicaid will pay the provider the lesser of: $62.17 per unit of service or the provider's usual and customary charge.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Family or Consumer Training



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (ID/DoD # or SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID#) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Baltimore, | STATE: MD

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 21200 | TELEPHONE (Include Area Code): (410) 333-3333

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (Current or Previous): YES | NO

a. INSURED'S DATE OF BIRTH: SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH: SEX: M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM _____ TO _____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM _____ TO _____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 2. _____

3. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 10 07		33		WO208			$61	86	1		NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ 61 86

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Original Date

SIGNED _____ DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #: EYZ Agency 500 Mount Street Baltimore, MD. (410) 333-3333

a. 5999999999 b.

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Home-Delivered Meals

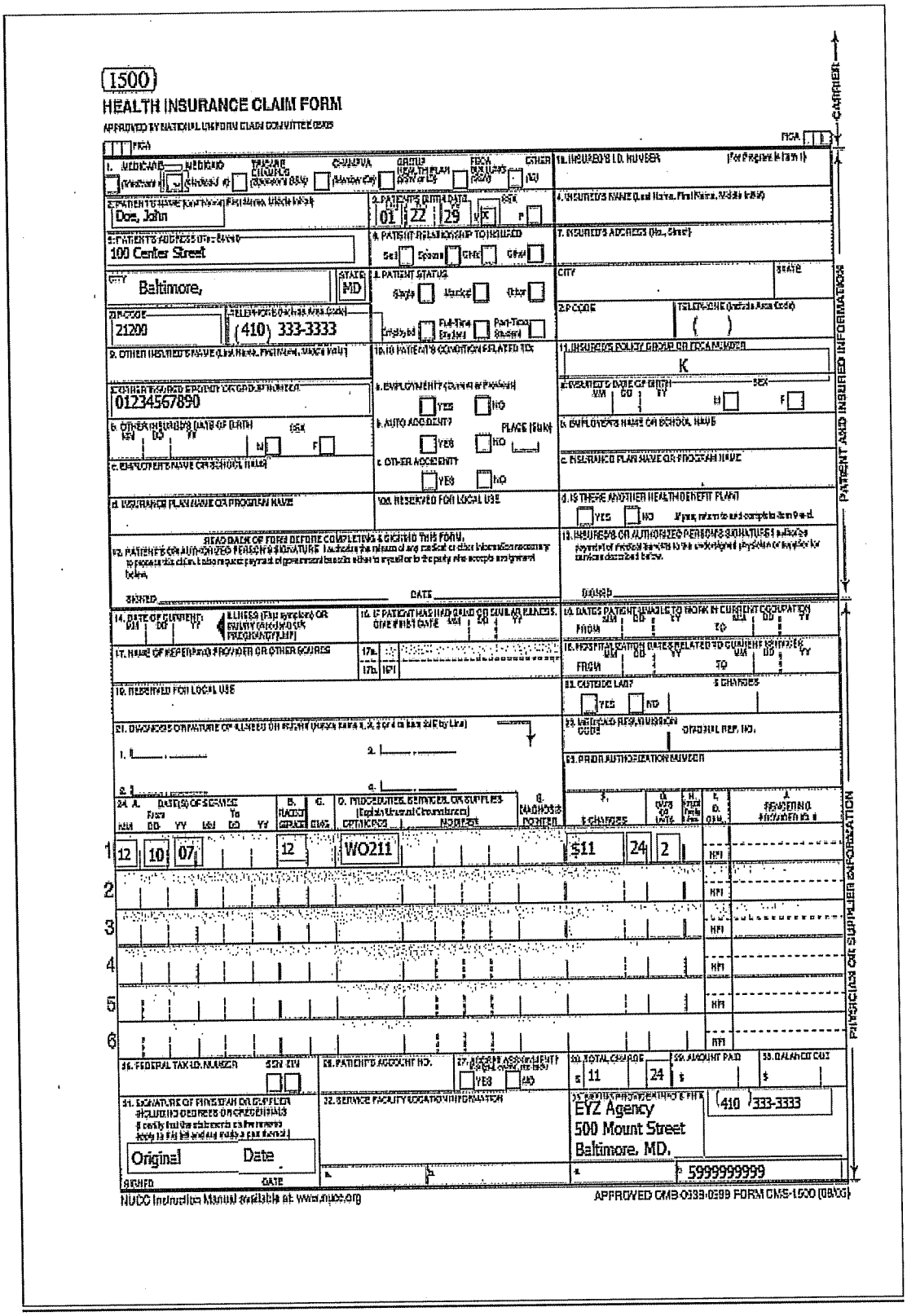
Procedure Code	Services	Unit of Service	*Rate per Unit
W0211	Home Delivered Meals	One Meal	$ 5.54 per meal

Following are specific instructions for billing Home-Delivered Meals under the Waiver for Older Adults.

- Providers must be approved to provide Home-Delivered Meals services under the Medicaid Waiver for Older Adults.
- A "unit of service" for Home-Delivered Meals is one meal delivered to the participant's home (includes the cost of food, food preparation, and delivery)
- This service, provider and the number of "units" (meals) must be listed in the participant's approved Plan of Care.
- Medicaid will pay a maximum of two units of service per day for a waiver participant.
- Services may only be provided to waiver participants residing at home.
- Medicaid will pay the provider the lesser of: $5.65 per meal or the provider's usual and customary charge to the general public for each delivered meal.
- Medicaid payment must be considered as payment in full for a home-delivered meal and may not supplement or be supplemented by payment from other sources, such as the Older Americans Act.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Note: Medicaid coverage, combined with Older Americans Act coverage through the local Area Agency on Aging, may not constitute the individual's full daily nutritional regimen of three meals.

Sample Claim for Home Delivered Meals



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE | MEDICAID | TRICARE CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME: Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 | SEX: M

4. INSURED'S NAME

5. PATIENT'S ADDRESS: 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self

7. INSURED'S ADDRESS

CITY: Baltimore, | STATE: MD

8. PATIENT STATUS: Single

ZIP CODE: 21200 | TELEPHONE: (410) 333-3333

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

9a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

9b. OTHER INSURED'S DATE OF BIRTH

10a. EMPLOYMENT? NO

11a. INSURED'S DATE OF BIRTH

9c. EMPLOYER'S NAME OR SCHOOL NAME

10b. AUTO ACCIDENT? NO

11b. EMPLOYER'S NAME OR SCHOOL NAME

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10c. OTHER ACCIDENT? NO

11c. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? NO

$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. MEDICAID RESUBMISSION CODE

ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12	10	07			12		WO211			$11	24	2	NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER: SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES

28. TOTAL CHARGE: $ 11 24

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #: (410) 333-3333

EYZ Agency
500 Mount Street
Baltimore, MD,

a. 5999999999

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Personal Care Services

Note:
Waiver Personal Care Services will not be pad for the same date of service as Medicaid State Plan Personal Care (MAPC) services.
Personal care services cannot be billed for any days that the participant was inpatient at a hospital, nursing facility or other medical institution.

Self-Employed Personal Care Aide – Non-Delegated

Procedure Code	Services	Unit of Service	*Rate per Unit
W0200	Self-Employed PC Aide: non–delegated services (no medication administration)	1 hour	$9.97 per hour

Following are specific instructions for billing for Self-Employed Personal Care – non-delegated services (without medication administration) under the Waiver for Older Adults:

- A provider must be enrolled to provide non-delegated services under the Medicaid Waiver for Older Adults.
- A "unit of service" is one hour (no partial hour increments are accepted).
- These services can only be provided to enrolled Waiver participants residing at home.
- This service, provider and units of service per day and/or week must be listed in the participant's approved Plan of Care.
- Self- Employed Personal Care Aides providing non-delegated services (without medication administration), must possess the following minimum qualifications:
  - A valid Medicaid Waiver provider number
  - Current First Aid and CPR (it is your responsibility to maintain these certifications)
  - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a nurse monitor assigned to the participant.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Self-Employed Personal Care Aide - Delegated Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0201	Self-Employed PC Aide – delegated services (with medication administration)	1 hour	$13.00 per hour

Following are specific instructions for billing for self-employed personal care –delegated services (with medication administration) under the Waiver for Older Adults

- A provider must be enrolled to provide delegated services under the Medicaid Waiver for Older Adults.
- A "unit of service" is one hour (no partial hour increments are accepted)

- These services can only be provided to approved Waiver participants residing at home
- This service, the provider and the units of service per day and/or week must be listed in the participant's approved Plan of Care.
- Self-employed personal care aides providing delegated (with medication administration) services must possess the following qualifications:
  - A valid Medicaid Waiver provider number
  - Current First Aid and CPR (it is your responsibility to maintain these certifications)
  - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a nurse monitor assigned to the participant
  - One of the following combinations of credentials:
    - Certified Nursing Assistant (CNA) and Medication Technician (MT) Certification, or
    - Geriatric Nursing Assistant (GNA) and Medication Technician (MT) Certification, or
    - Certified Medication Technician (CMA) You must have a CNA before receiving a CMA)

  Note: Certifications **must** be **current** and **verifiable** from the Maryland Board of Nursing.
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Agency Non-Delegated Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0202	Agency-Employed PC Aide -non-delegated services (no medication administration)	1 hour	$12.75

Following are specific instructions for billing Agency-Employed Personal Care-Aides providing non-delegated services (without medication administration) under the Waiver for Older Adults:

- The Agency must be enrolled to provide personal care services non-delegated services (no medication administration) under the Medicaid Waiver for Older Adults.
- A "unit of service" is one hour (no partial hour increments are accepted).
- This service, the provider and the units of service per day and/or week must be listed in the participant's approved Plan of Care.
- These services can only be provided to approved Waiver participants residing at home
- Agency employed personal care aides providing non-delegated services (without medication administration), must possess the following minimum qualifications:
  - Current First Aid and CPR (it is your responsibility to maintain these certifications)
  - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a licensed registered nurse or nurse monitor as stated before?
  - A criminal background check submitted by Criminal Justice Information Services (CJIS) in the Agency's name, verifying that the employee has a clear record that contains no probation before judgment(s) or criminal conviction (The agency responsibility is to maintain current and up-to-date records on each employee).
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Agency Delegated Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0203	Agency-Employed PC aide - delegated services (with medication administration)	1 hour	$16.61

Following are specific instructions for billing Agency-Employed Personal Care-Aides providing delegated services (with medication administration) under the Waiver for Older Adults:

- Personal Care Agencies must be enrolled and approved to provide delegated services (with medication administration) under the Medicaid Waiver for Older Adults
- A "unit of service" is one hour (no partial hour increments are accepted)
- Agencies must be approved to provide Agency Personal Care Services - delegated (with medication administration) under the Medicaid Waiver for Older Adults.
- This service, the provider and the units of service per day and/or week must be listed in the participant's approved Plan of Care.
- These services can only be provided to approved Waiver participants residing at home
- Agency employed personal care aides providing delegated services (with medication administration must possess the following qualifications:
  - Current First Aid and CPR
  - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a licensed registered nurse
  - A criminal background check submitted by Criminal Justice Information Services (CJIS) in the hiring Agency's name, verifying that the employee has a clear record that contains no probation before judgment(s) or criminal conviction (The agency is responsibility to maintain current and up-to-date records on each employee).
  - One of the following combinations of credentials:
    - Certified Nursing Assistant (CNA and Medication Technician (MT) Certification, or
    - Geriatric Nursing Assistant (GNA) and Medication Technician (MT) Certification, or
    - Certified Medicine Aide (CMA)
  - Note: These certifications **must** be **current** and **verifiable** from the Maryland Board of Nursing. (The agency responsibility is to maintain current and up-to-date records on each employee and to verify that certifications are current and remain current).

- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Agency Nurse Monitoring Services

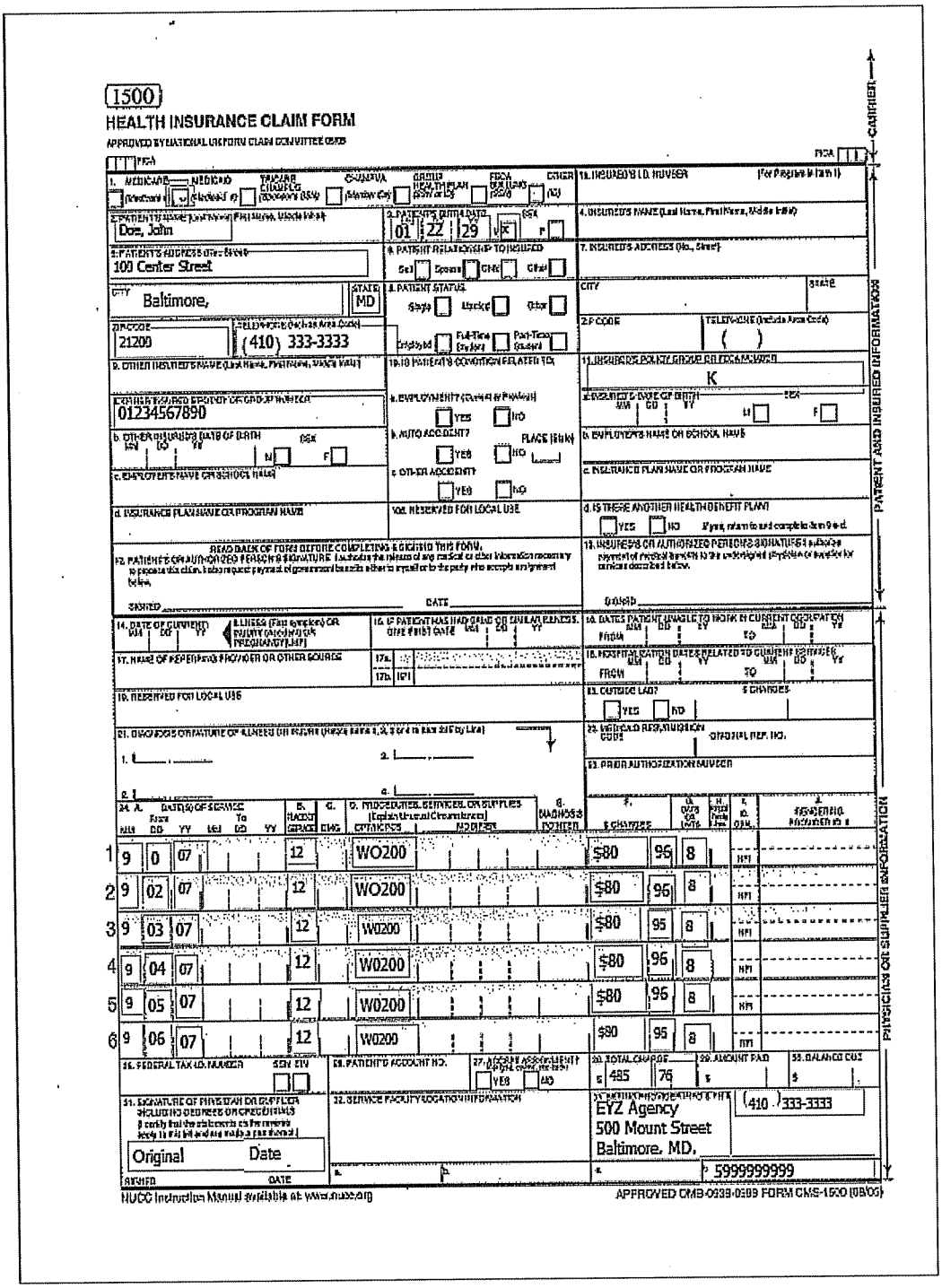
Procedure Code	Services	Unit of Service	*Rate per Unit
W0204	Personal Care Agency Nurse Monitoring	1 hour	$60.93

Following are specific instructions for billing Agency-Employed Personal Care-Aides providing delegated services
(with medication administration) under the Waiver for Older Adults:

- Providers must be approved to provide Agency Nurse Monitoring Services under the Medicaid Waiver for Older Adults.

- A "unit of service" for Nurse Monitor is one (1) hour (no partial hour increments are accepted).
- This service, the provider and the units of service per month must be listed in the participant's approved Plan of Care.
- This services can only be provided to approved Waiver participants residing at home
- Agency Employed Nurse Monitors must possess a RN license, **current** and **verifiable** from the Maryland Board of Nursing. (The agency responsibility is to maintain current and up-to-date records on each employee and to verify that certifications are current and remain current).
- Nurse Monitoring services may include, but are not limited to:
  - Assessing the participant's medical condition.
  - Developing a waiver participant's specific service plan (Caregiver Service Plan)
  - Evaluating a prospective personal care aide's ability to understand and carry out the participant specific plan-of-care (Caregiver Assessment).
  - Providing instruction and training to a personal care aide in the performance of specific services listed in the participant's specific service plan.
  - Supervising the care given to a waiver participant by a personal care aide
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care
- Requests for reimbursement must include a copy of a DHMH 4658D –Nurse Monitor Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Self- Employed Personal Care Aide: Non-Delegated: 8 Hours Per Day, Seven Days Per Week



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE — MEDICAID — TRICARE CHAMPUS — CHAMPVA — GROUP HEALTH PLAN — FECA BLK LUNG — OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 — SEX: M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self

7. INSURED'S ADDRESS (No., Street)

CITY: Baltimore, — STATE: MD

8. PATIENT STATUS: Single — Married — Other; Employed — Full-Time Student — Part-Time Student

CITY — STATE

ZIP CODE: 21200 — TELEPHONE (Include Area Code): (410) 333-3333

ZIP CODE — TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH — SEX

b. OTHER INSURED'S DATE OF BIRTH — SEX

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L — 2. L

3. L — 4. L

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	9	0	07			12		WO200			$80	96	8	NPI	
2	9	02	07			12		WO200			$80	96	8	NPI	
3	9	03	07			12		WO200			$80	96	8	NPI	
4	9	04	07			12		WO200			$80	96	8	NPI	
5	9	05	07			12		WO200			$80	96	8	NPI	
6	9	06	07			12		WO200			$80	96	8	NPI	

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 485.76

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.

Original Date

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. — b.

33. BILLING PROVIDER INFO & PH #

EYZ Agency
500 Mount Street
Baltimore, MD,

(410) 333-3333

a. — b. 5999999999

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Sample Claim for Agency Personal Care– Delegated Nursing Service: 10 hours/day, Seven Days Per Week

WAIVER FOR OLDER ADULT BILLING CLAIM FORM

Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging

Participant's Name : John Doe	Participant's Medicaid Number: 0 1 2 3 4 5 6 7 8 9 0
Address: 100 Center Street	
City: Baltimore / State: Maryland	Participant Birth Date: Mm 1 / Dd 22 / Yyyy 1929
Zip 21200 / Telephone 410-222-3333	Eligibility Category: K / Participant Sex: [X] Male [ ] Female

	Date Billed MM	DD	YY	Place Of Service All Other	PCA	Waiver Procedure Code	Charges		Days/Units	
1	01	01	03	33	12	W1005	165	30	10	1
2	01	02	03		12	W1005	165	30	10	2
3	01	03	03		12	W1005	165	30	10	3
4		04	03		12	W1005	165	30	10	4
5	01	05	03		12	W1005	165	30	10	5
6	01	06	03		12	W1005	165	30	10	6
7	01	07	03		12	W1005	165	30	10	7
8	01	08	03		12	W1005	165	30	10	8
9	01	09	03		12	W1005	165	30	10	9
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21	01	21	03		12	W1005	165	30	10	21
22	01	22	03		12	W1005	165	30	10	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31

Your Original Signature	PROVIDER/FACILITY NAME ABC AGENCY	$ 3858.40 TOTAL AMOUNT	TOTAL Units
PROVIDER SIGNATURE	ACCOUNT STREET PROVIDER ADDRESS		
DATE	CITY, STATE, ZIP BALTIMORE, MD, 21200	TELEPHONE 410-222-2222	
(AAA) Claims Processor	PROVIDER # 9 9 9 9 9 9 9 9 9 9 9 9	MDOA/6-07-07- FINAL	

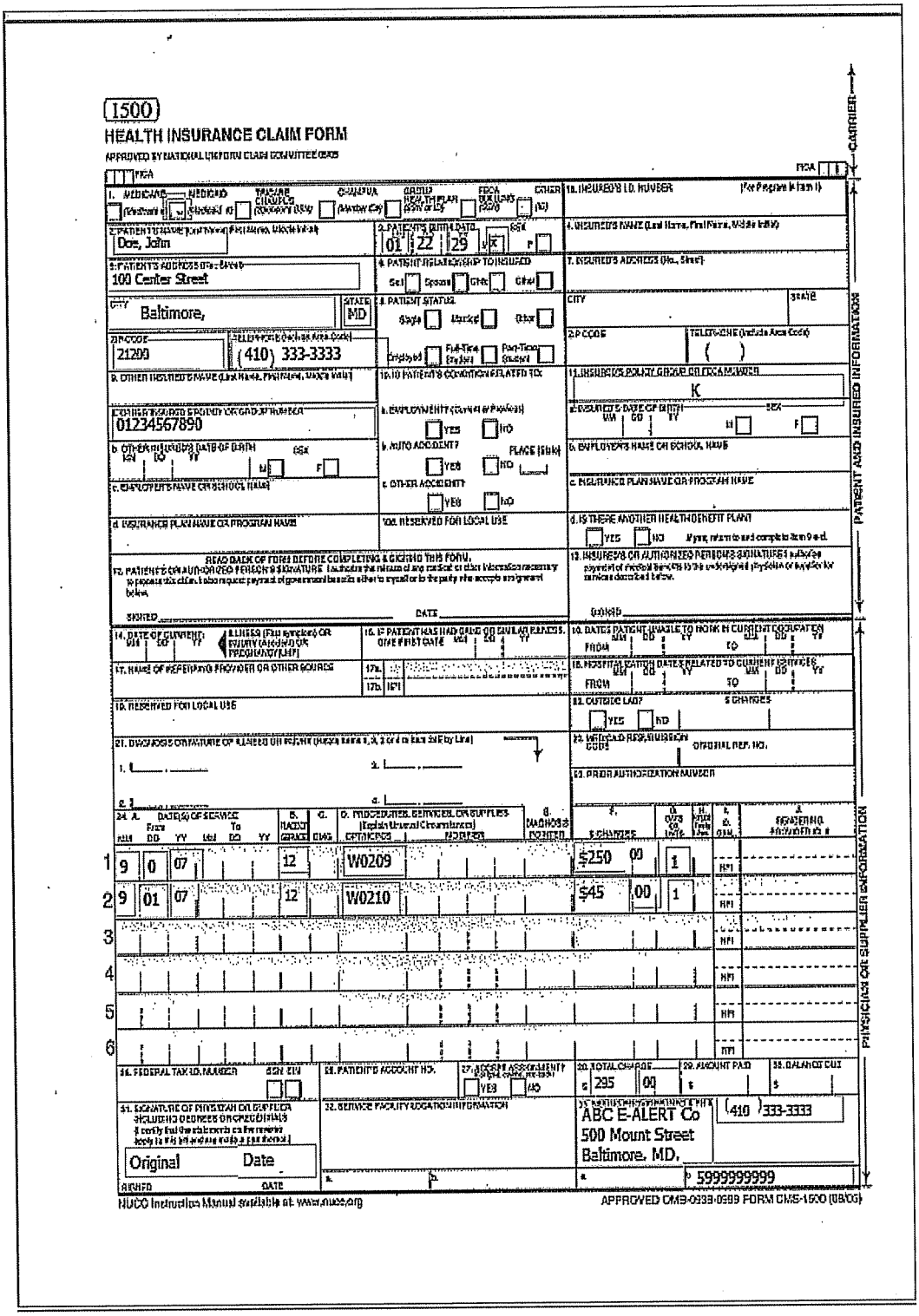
Personal Emergency Response Systems

Procedure Code	Services	Unit of Service	*Rate per Unit
W0209	Purchase and/or installation, maintenance or repair of a monitoring device, equipment or system	1 unit a year	Actual Cost (maximum of $1,000)
W0210	Monthly rental cost including monitoring and maintenance of system	1 month	The lesser of $45.00 or the provider's usual and customary charge to the public/month

Following are specific instructions for billing a Personal Emergency Response Systems under the Waiver for Older Adults.

- Providers must be approved to provide Personal Emergency System services under the Medicaid Waiver for Older Adults.
- A "unit of service" for a Personal Emergency Response System –Device or Equipment (W0209) is one installed unit.
- A "unit of service" for Personal Emergency Response System –Rental, Monitoring and Maintenance of Device or Equipment (W0210) is a month.
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care.
- Services may only be provided to waiver participants residing at home.
- See COMAR 10.09.54.09 & .25 for additional information on this service.
- Medicaid will pay the provider the lesser of: $1000 per unit or the provider's usual and customary charge to the general public for Procedure Code W0209.
- Medicaid will pay the provider the lesser of: $45.00 or the provider's usual and customary charge to the general public per month for Procedure Code W0210.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Agency Personal Emergency Response System (W0209) and Monthly Rental (W0210



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE — MEDICAID — TRICARE CHAMPUS — CHAMPVA — GROUP HEALTH PLAN — FECA BLK LUNG — OTHER

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 — SEX: M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self

7. INSURED'S ADDRESS (No., Street)

CITY: Baltimore, — STATE: MD

8. PATIENT STATUS: Single

CITY — STATE

ZIP CODE: 21209 — TELEPHONE (Include Area Code): (410) 333-3333

ZIP CODE — TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (Current or Previous) NO

a. INSURED'S DATE OF BIRTH — SEX

b. OTHER INSURED'S DATE OF BIRTH — SEX

b. AUTO ACCIDENT? NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

SIGNED — DATE — SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items A, B, C or D to Item 24E by Line)

1. L — 2. L

3. L — 4. L

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 9 0 07		12		W0209			$250 00	1		NPI	
2 9 01 07		12		W0210			$45 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES

28. TOTAL CHARGE: $ 295 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

I certify that the statements on the reverse apply to this bill and are made a part thereof.

Original Date

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION

ABC E-ALERT Co
500 Mount Street
Baltimore, MD,

(410) 333-3333

a. — b. 5999999999

33. BILLING PROVIDER INFO & PH #

a. — b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Respite Care

Self-Employed Respite Care Aide

Procedure Code	Services	Unit of Service	*Rate per Unit
W0205	Self-Employed Respite Care Aide	1 hour	$9.97 per Hour

Following are specific instructions for billing for Self-Employed Respite Care Aides under the Waiver for Older Adults:

- A Respite Care aide must be enrolled as a self-employed personal care aide **and** a self-employed respite care provider under the Medicaid Waiver.
- A "unit of service" is one hour (no partial hour increments are accepted)
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- These services can only be provided to approved Waiver participants residing at home
- Self employed Respite Care aides must possess the following minimum qualifications:
  - A valid Medicaid Waiver provider number
  - Current First Aid and CPR (it is your responsibility to maintain these certifications)
  - Ability to understand the instructions in the participant's plan of care, specific service plan (Caregiver Service Plan) and perform required duties satisfactorily in the presence of a licensed registered nurse.
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

NOTE: 1. Medicaid will pay for no more than 12 hours of respite care services in a 24 hour period under Procedure Code W0205.
2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Agency Employed Respite Care

Procedure Code	Services	Unit of Service	*Rate per Unit
W0206	Agency - Employed Respite Care Aide	1 hour	$12.75 per hour

Following are specific instructions for billing for Agency-Employed Respite Care Aides under the Waiver for Older Adults:

- A provider must be enrolled to provide personal care services **and** respite care services under the Medicaid Waiver.
- A "unit of service" is one hour (no partial hour increments are accepted)*.
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care

- These services can only be provided to approved Waiver participants residing at home
- Agency Employed Respite Care aides must possess the following minimum qualifications:
  - A valid Medicaid Waiver provider number
  - Current First Aid and CPR (it is your responsibility to maintain these certifications)
  - Ability to understand the instructions in the participant's plan of care, specific service plan (Caregiver Service Plan) and perform required duties satisfactorily in the presence of a licensed registered nurse.
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

*NOTE: 1. Medicaid will pay for no more than 12 hours of respite care services in a 24 hour period under Procedure Code W0206.
2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Respite Care in a Nursing Facility

Procedure Code	Services	Unit of Service	*Rate per Unit
W0220	Respite Care in a Nursing Facility	1 day	$132.91p er day

Following are specific instructions for billing Respite Care in a Nursing Facility under the Waiver for Older Adults:

- The facility must be enrolled to provide Respite Care Services under the Medicaid Waiver for Older Adults
- A "unit of service" is one (1) day up to a maximum of 14 days per year
- Services can only be provided to approved Waiver participants This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- This service can only be provided to approved Waiver participants residing at home
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Medicaid will pay the provider the lesser of: $135.62 /day or the provider's usual and customary charge for the general public. Note: Respite care services are provided on a short-term basis and must be administered according to the client's plan of care.
- Provider may only bill for units of services actually provided, not to exceed those specified in the
  Participant's approved Plan of Care.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Note: 1. Medicaid will pay for no more than 14 day of respite care services in a 12 month period under Procedure Code W0220.
2 Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Respite Care in an Assisted Living Facility

Procedure Code	Services	Unit of Service	*Rate per Unit
W0221	Respite Care Assisted Living Facility	1 day	$70.88 per day

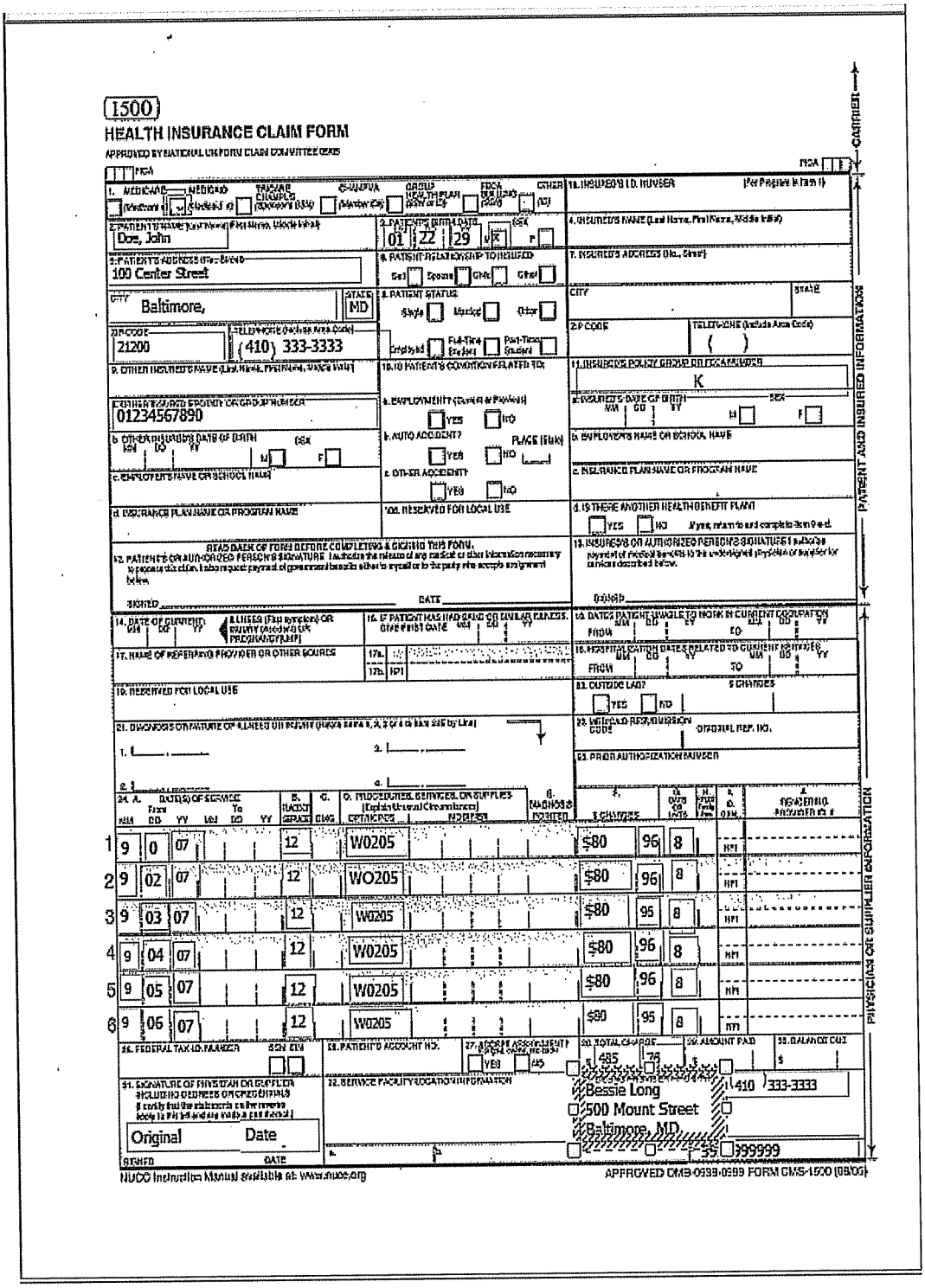
Following are specific instructions for billing Respite Care in an Assisted Living Facility under the Waiver for Older Adults:

- A provider must be enrolled to provide Assisted Living Services and Respite Care Services under the Medicaid Waiver for Older Adults
- A "unit of service" is one day up to a maximum of 14 days per year.
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- This service can only be provided to approved Waiver participants residing at home
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Medicaid will pay the provider the lesser of: $72.33 per day or the provider's usual and customary charge for the general public. Note: Respite care services are provided on a short-term basis and must be administered according to the participant's Plan of Care.
- Provider may only bill for units of services actually provided, not to exceed those specified in the Participant's approved Plan of Care.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

NOTE: 1. Medicaid will pay for no more than 14 day of respite care services in a 12 month period under Procedure Code W0221.

2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Sample Claim for Self –Employed Personal Care Aide Enrolled to Provide Respite Care



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — 1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 — SEX: M

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY: Baltimore, — STATE: MD

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY — STATE

ZIP CODE: 21200 — TELEPHONE (Include Area Code): (410) 333-3333

ZIP CODE — TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (Current or Previous): YES / NO

a. INSURED'S DATE OF BIRTH — SEX: M / F

b. OTHER INSURED'S DATE OF BIRTH — SEX: M / F

b. AUTO ACCIDENT? YES / NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES / NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES / NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 2. _____

3. _____ 4. _____

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 9 0 07		12		W0205			$80	96	8	NPI	
2 9 02 07		12		W0205			$80	96	8	NPI	
3 9 03 07		12		W0205			$80	96	8	NPI	
4 9 04 07		12		W0205			$80	96	8	NPI	
5 9 05 07		12		W0205			$80	96	8	NPI	
6 9 06 07		12		W0205			$80	96	8	NPI	

25. FEDERAL TAX I.D. NUMBER — SSN / EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO

28. TOTAL CHARGE: $ 485 76

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.

Original Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Bessie Long

500 Mount Street

Baltimore, MD

(410) 333-3333

35 999999

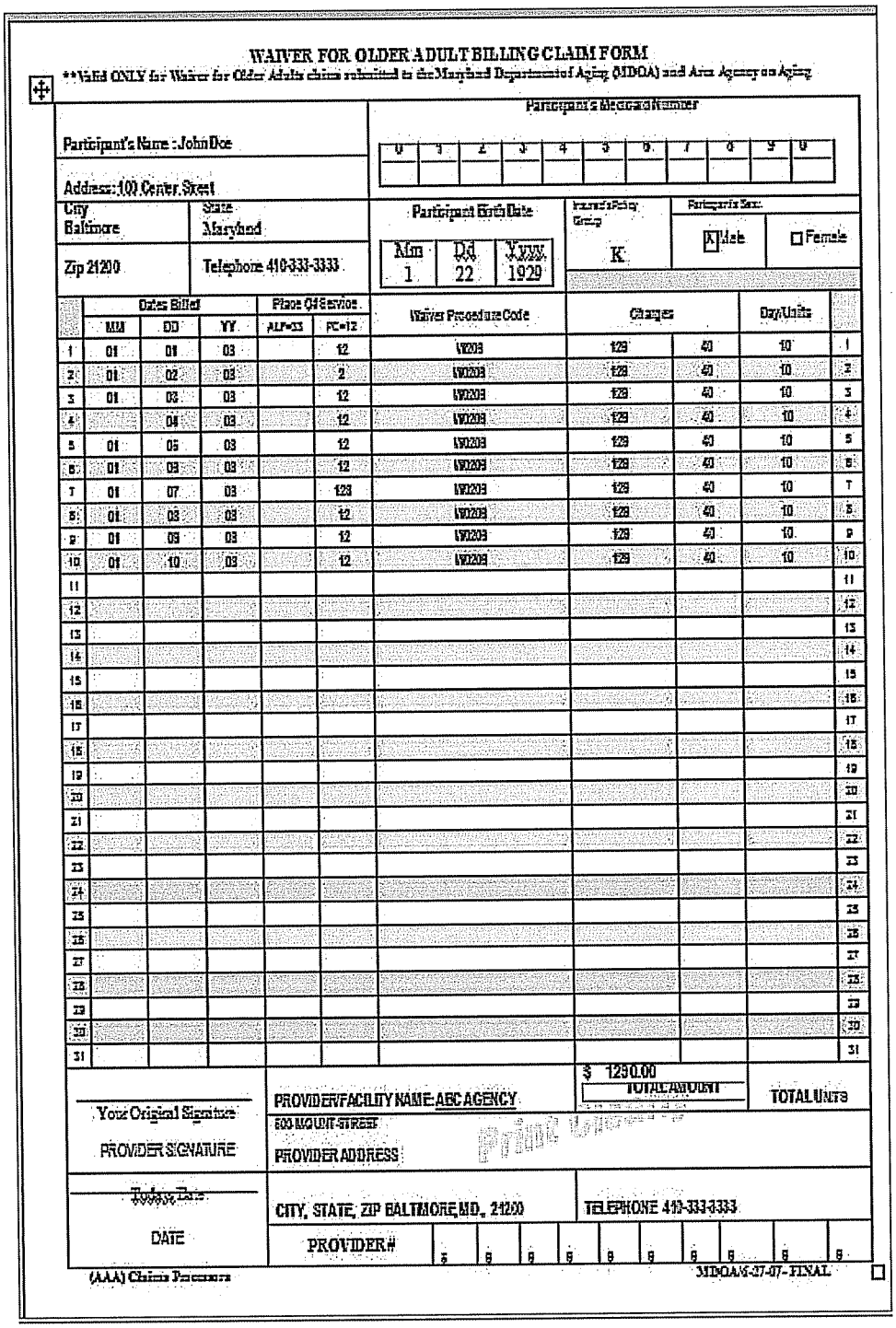
PIN# — GRP#

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Sample Claim for Agency Personal Care Provider Enrolled to Provide Respite Care Service



WAIVER FOR OLDER ADULT BILLING CLAIM FORM

**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging

Participant's Name : John Doe

Participant's Medicaid Number: 0 1 2 3 4 5 6 7 8 9 0

Address: 100 Center Street

City: Baltimore | State: Maryland

Zip: 21200 | Telephone: 410-333-3333

Participant Birth Date: Mm 1 | Dd 22 | Yyyy 1929

Insured's Policy Group: K

Participant's Sex: [X] Male [ ] Female

	Dates Billed MM	DD	YY	Place Of Service ALP=33	POS=12	Waiver Procedure Code	Charges		Day/Units	
1	01	01	03		12	W0209	129	40	10	1
2	01	02	03		2	W0209	129	40	10	2
3	01	03	03		12	W0209	129	40	10	3
4		04	03		12	W0209	129	40	10	4
5	01	05	03		12	W0209	129	40	10	5
6	01	06	03		12	W0209	129	40	10	6
7	01	07	03		123	W0209	129	40	10	7
8	01	08	03		12	W0209	129	40	10	8
9	01	09	03		12	W0209	129	40	10	9
10	01	10	03		12	W0209	129	40	10	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
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23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31

Your Original Signature
PROVIDER SIGNATURE

PROVIDER/FACILITY NAME: ABC AGENCY
600 MOUNT STREET
PROVIDER ADDRESS

$ 1290.00
TOTAL AMOUNT

TOTAL UNITS

Today's Date
DATE

CITY, STATE, ZIP BALTIMORE, MD., 21200

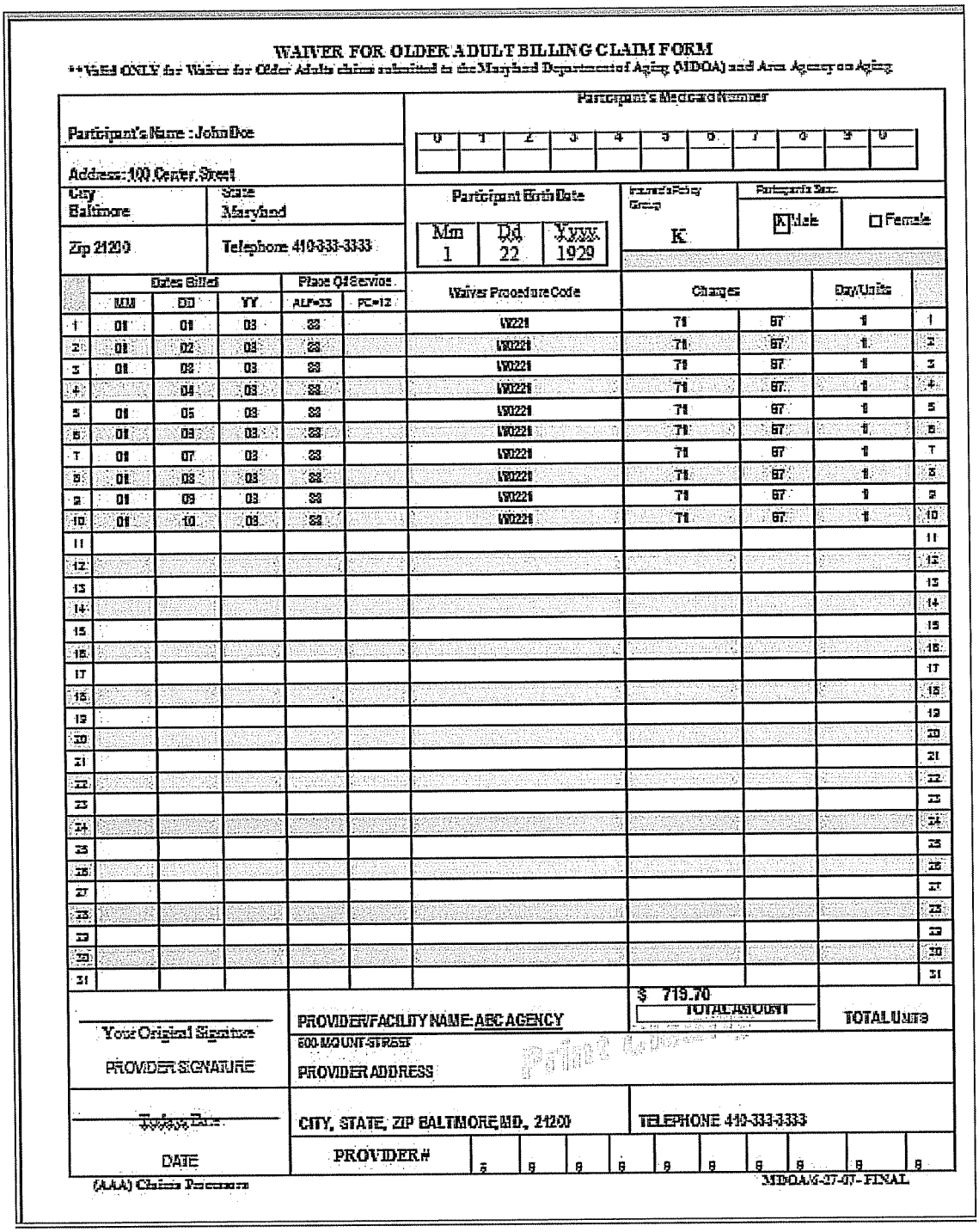
TELEPHONE 410-333-3333

PROVIDER# 5 8 8 8 8 8 8 8 8 8 8

(AAA) Claims Processor

MDOA/6-27-07-FINAL

Sample Claim for Assisted Living Facility Enrolled to Provide Respite Care Service



WAIVER FOR OLDER ADULT BILLING CLAIM FORM

**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging

Participant's Name : John Doe

Participant's Medicaid Number: 0 1 2 3 4 5 6 7 8 9 0

Address: 100 Center Street

City: Baltimore | State: Maryland

Zip: 21200 | Telephone: 410-333-3333

Participant Birth Date: Mm 1 | Dd 22 | Yyyy 1929

Insured's Policy Group: K

Participant's Sex: [X] Male [ ] Female

	Dates Billed MM	DD	YY	Place Of Service ALF=33	PC=12	Waiver Procedure Code	Charges		Day/Units	
1	01	01	03	33		W0221	71	97	1	1
2	01	02	03	33		W0221	71	97	1	2
3	01	03	03	33		W0221	71	97	1	3
4		04	03	33		W0221	71	97	1	4
5	01	05	03	33		W0221	71	97	1	5
6	01	06	03	33		W0221	71	97	1	6
7	01	07	03	33		W0221	71	97	1	7
8	01	08	03	33		W0221	71	97	1	8
9	01	09	03	33		W0221	71	97	1	9
10	01	10	03	33		W0221	71	97	1	10
11										11
12										12
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26										26
27										27
28										28
29										29
30										30
31										31

$ 715.70 TOTAL AMOUNT | TOTAL UNITS

Your Original Signature
PROVIDER SIGNATURE

PROVIDER/FACILITY NAME: ABC AGENCY

600 MOUNT STREET
PROVIDER ADDRESS

Today's Date
DATE

CITY, STATE, ZIP BALTIMORE, MD. 21200

TELEPHONE 410-333-3333

PROVIDER # 5 9 9 9 9 9 9 9 9 9

(AAA) Claims Processor

MDOA/6-27-07 - FINAL

Senior Center Plus

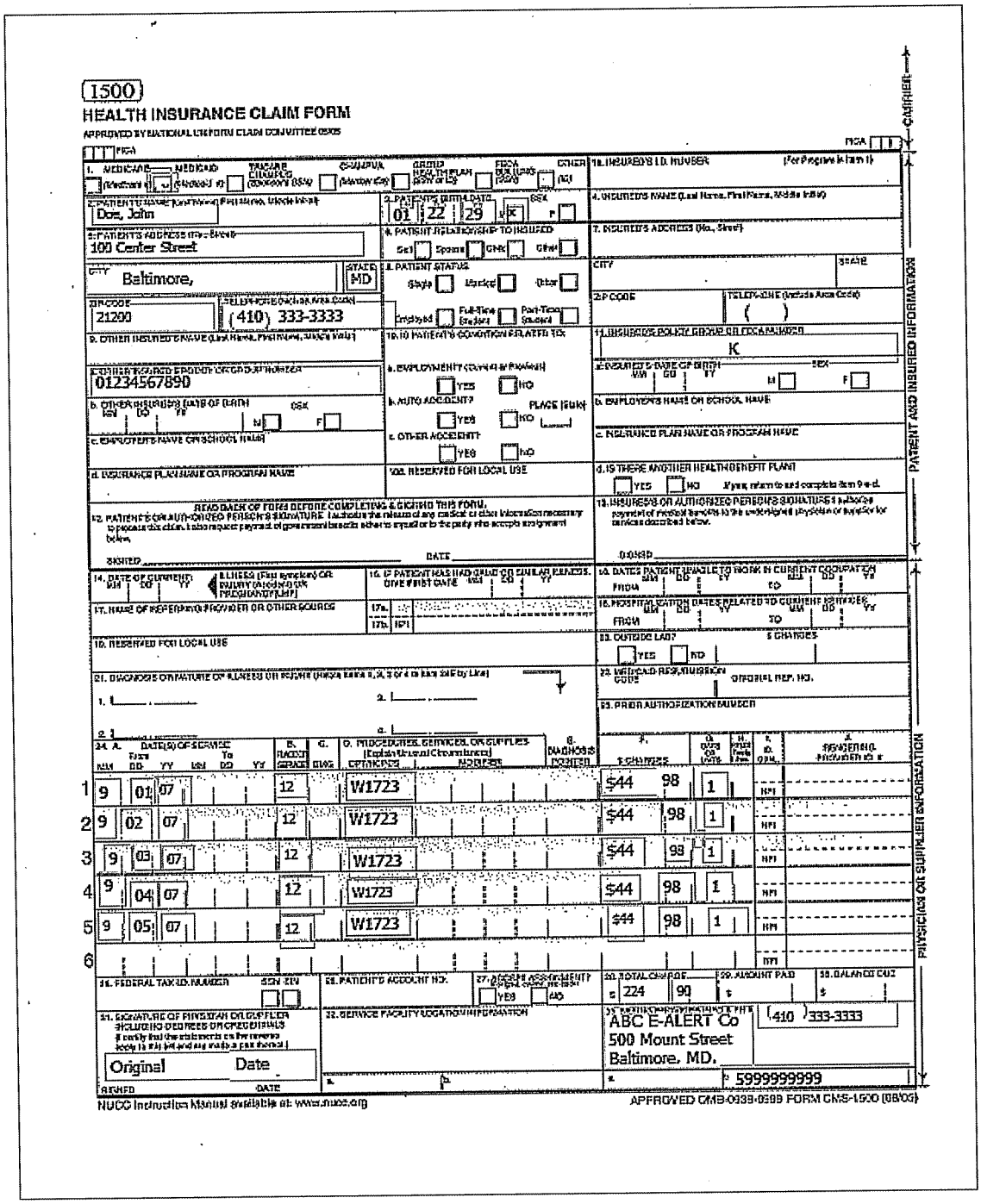
Procedure Code	Services	Unit of Service	Rate per Unit
W1723	Senior Center Plus	1 day	$44.31 per day

Following are specific instructions for billing Senior Center Plus services under the Waiver for Older Adults.

- The facility must be enrolled as a Senior Center Plus provider under the Waiver for Older Adults.
- A "unit of service" is a day of attendance for at least 4 hours, and includes at least one meal (and a snack if the day program exceeds 6 hours).
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- Senior Center Plus services may be provided to waiver participants residing either at home or in an assisted living facility.
- See COMAR 10.09.54.05 D & .21 for additional information on this service
- Medicaid will pay the provider the lesser of: $45.21 per day or the provider's usual and customary charge for the general public.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** *(Appendix B)* with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Note: Medicaid will not pay for both Senior Center Plus and Medicaid State Plan day care for a waiver participant on the same date.

Sample Claim for Senior Center Plus



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE — MEDICAID — TRICARE CHAMPUS — CHAMPVA — GROUP HEALTH PLAN — FECA BLK LUNG — OTHER

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME: Doe, John

3. PATIENT'S BIRTH DATE: 01 22 29 — SEX: M

4. INSURED'S NAME

5. PATIENT'S ADDRESS: 100 Center Street

6. PATIENT RELATIONSHIP TO INSURED: Self

7. INSURED'S ADDRESS

CITY: Baltimore, — STATE: MD

8. PATIENT STATUS: Single — Married — Other; Employed — Full-Time Student — Part-Time Student

ZIP CODE: 21200 — TELEPHONE: (410) 333-3333

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: K

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 01234567890

a. EMPLOYMENT? (CURRENT OR PREVIOUS) — YES — NO

a. INSURED'S DATE OF BIRTH — SEX

b. OTHER INSURED'S DATE OF BIRTH — SEX

b. AUTO ACCIDENT? — PLACE (STATE)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES — NO — If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? — YES — NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. L — 2. — 3. — 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 9 01 07		12		W1723			$44 98	1		NPI	
2 9 02 07		12		W1723			$44 98	1		NPI	
3 9 03 07		12		W1723			$44 98	1		NPI	
4 9 04 07		12		W1723			$44 98	1		NPI	
5 9 05 07		12		W1723			$44 98	1		NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER — SSN — EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) — YES — NO

28. TOTAL CHARGE: $ 224 98

29. AMOUNT PAID: $ 90

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Original Date

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #: ABC E-ALERT Co, 500 Mount Street, Baltimore, MD. (410) 333-3333

a. — b. 59999999999

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

APPENDIX A

CAREGIVER TIMESHEET

(DHMH-4659)

Medicaid Home and Community-Based Services Waiver Program:
Caregiver Time Sheet/Caregiver Service Record Form

Waiver Program: ☐ Waiver for Older Adults (WOA) ☐ Living at Home Waiver (LAH)

Waiver Participant Name (Print) ____________________ [illegible] Name (Print) ____________________

Check applicable box: Provider Type: ☐ Independent ☐ Agency ____________________ (Agency)

Day	Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours	Participant Initials
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							

Participant/Representative's Signature ____________________ Date ____________________

Provider's Signature ____________________ Date ____________________

By signing above, the caregiver certifies the services rendered are in accordance with the authorized Plan of Service/Plan of Care on the above dates of service as specified in the Caregiver Service Plan and that the caregiver delivered to the participant all service hours listed on this form.

Enter "YES" or "NO" in the boxes next to the task to show tasks you did on each day.

Task	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Comments
Personal Hygiene (i.e. bathing, hair, oral, nail, and skin care)								
Toileting (i.e. bladder, bowel, and bed pan routines, movement to/from bathroom)								
Dressing & Changing Clothes								
Mobility & Transfers								
Eating & Drinking								
Medications								
Light Housekeeping (e.g. Laundry)								
Errands								
Other (please specify):								

Independent caregivers – Attach the white copy of this signed time sheet to the appropriate program billing form, (LAH – [illegible] or WOA – [illegible]). Submit the forms for payment.
Agency caregiver – Submit the white copy of this signed time sheet to your agency. They will attach the white copy of the time sheet to the appropriate billing form and forward the documents to the billing department for payment.

[illegible]
Immediately report any [illegible] to Adult Protective Services at [illegible].

[illegible] Approved [illegible]
White Copy – Billing Department Yellow Copy – Nurse Monitor Pink Copy – Participant/Representative Goldenrod – Caregiver

APPENDIX B

MODIFIED BILLING FORM

WAIVER FOR OLDER ADULT BILLING CLAIM FORM

Participant's Name (Last Name, First Name, MI)	Participant's Medicaid Number
Address	
City / State	Participant Birth Date (MM DD YYYY) / Insurance Policy Group: K / Participant's Sex: ☐ Male ☐ Female
Zip / Telephone	

	Dates Billed			Place Of Service		Waiver Procedure Code	Charges		Day/Units	
	MM	DD	YY	AP=33	PC=12					
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31

PROVIDER SIGNATURE	PROVIDER FACILITY NAME	0 SUBTOTAL	TOTAL UNITS
	PROVIDER ADDRESS		
DATE	CITY, STATE, ZIP	TELEPHONE	
	PROVIDER#		

**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging (AAA) Claims Processors

MDOA/6-27-07- FINAL

APPENDIX C

NURSE MONITOR TIMESHEET

(DHMH-4658D)

Medicaid Home and Community-Based Services Waiver Programs
Nurse Monitor Time Sheet (use only for people at home)

Waiver Program: ☐ Waiver for Older Adults (WOA) ☐ Living at Home Waiver (LAH)

Waiver Participant's Name (Print) _____

Nurse Monitor's Name (Print) _____

Please check all applicable boxes below:

Provider Type: ☐ Agency _____ (Name) ☐ Independent

Type of visit:

Waiver for Older Adults

☐ Initial Visit
☐ Monthly Visit
☐ Other _____ (note frequency)

Living at Home Waiver

☐ Initial Visit
☐ 45 Day Visit
☐ 3 Month Visit
☐ 6 Month Visit
☐ Other _____ (note frequency)

Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours

Participant and Provider Certification – Please carefully read, date and sign this section.

By signing this statement, the Nurse Monitor certifies that the delegated nursing functions, participant assessment and caregivers' performance is in accordance with the authorized Plan of Service/Care. The nurse monitor and participant also certify that the nurse monitor provided the service hours on the date listed on this form.

Participant's/ Representative's Signature _____ Date _____

Nurse Monitor's Signature _____ Date _____

LAH – Independent nurse monitor – Attach the white copy of this signed timesheet to the appropriate program billing form (LAH – DHHR 4552.) Send both forms to the billing department for payment.
LAH and WOA – Agency nurse monitor – Submit the white copy of this signed time sheet to your agency. They will attach the white copy of this timesheet to the appropriate billing document for payment.

Immediately report any serious issues or participant needs to the Living at Home Waiver 1-877-481-9448 or the Waiver for Older Adults 1-800-225-5125.

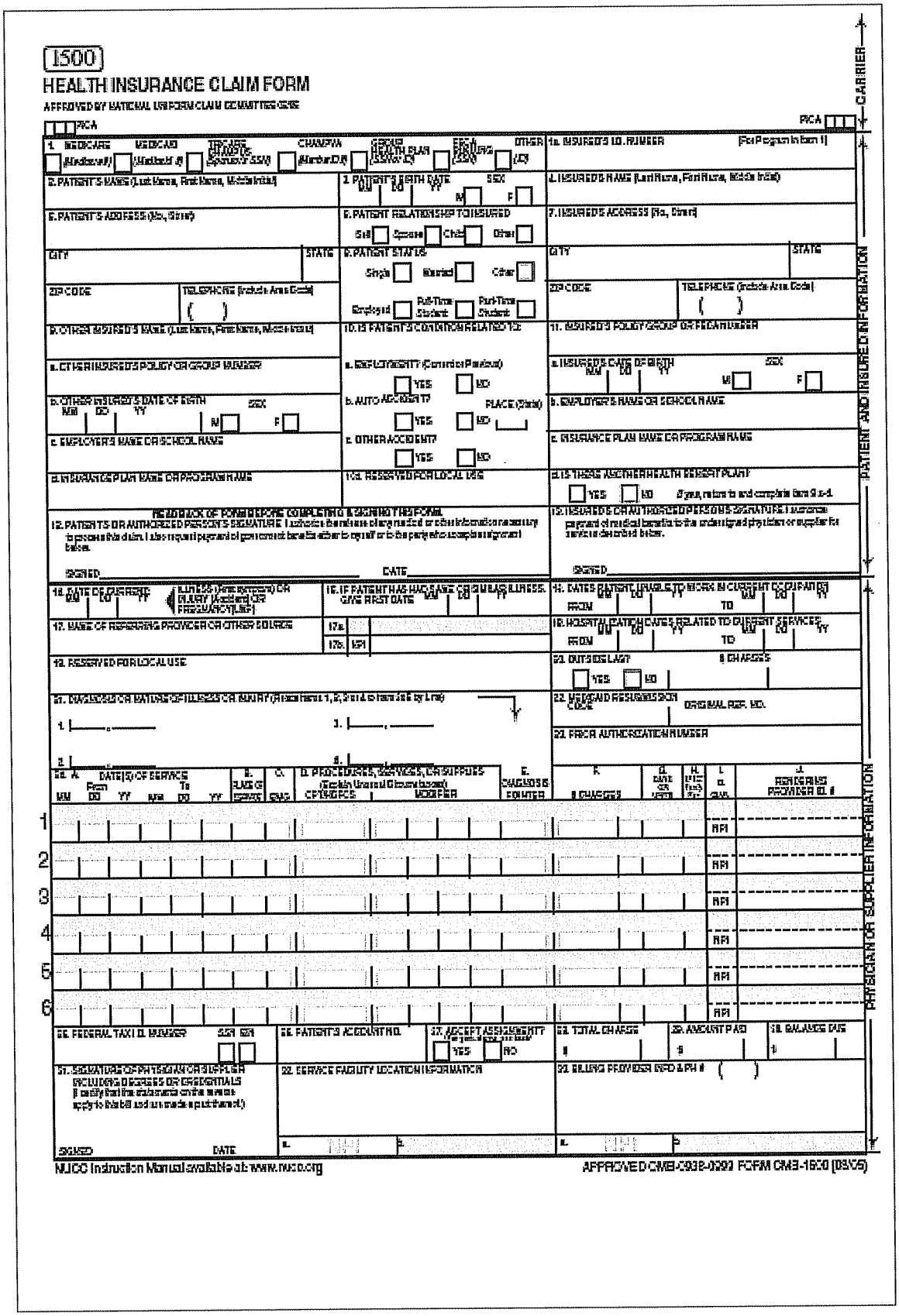
Immediately report suspected abuse, neglect or exploitation to Adult Protective Services at 1-800-917-7585. Report any serious health or safety concerns to the case manager.

DHHR 4552 (3 – 15) Approved 7/01/15

White Copy – Billing Department Yellow Copy – Nurse Monitor Pink Copy – Participant/Representative

APPENDIX D

CMS-1500 BILLING FORM



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid #) TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)

a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH SEX

b. AUTO ACCIDENT?

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

APPENDIX E

AAA Contact Information

Local Departments of Aging

Allegany County
Lynn Marlowe
HRDC, Inc.
19 Frederick Street
Cumberland, MD 21502
301-777-5970, ext. 144
301-777-1685

Anne Arundel County
Therese Tobiczyk
Anne Arundel County Dept. of Aging
2666 Riva Road, Suite 400
Annapolis, MD 21401
410-222-4464
410-222-4358 FAX

Baltimore City
Teresa Jeter-Cutting
Baltimore City Commission on Aging
10 N. Calvert Street, Suite 300
Baltimore, MD 21202
410-396-4932
410-545-7805 FAX

Baltimore County
Michael Lehmuth
Baltimore County Dept. of Aging
611 Central Avenue
Towson, MD 21204
410-887-8739
410-887-8796 FAX

MAC Incorporated
Kathy Walker
1504 Riverside Drive
Salisbury, MD 21801
410-742-0505 ext. 108
410-742-0525 FAX ext. 138

Montgomery County
Mario Wawrzusin
Montgomery County
Division of Aging & Disability Services
401 Hungerford Drive, 2nd Floor
Rockville, MD 20850
240-777-3851
240-777-3183 FAX

Prince George's County
Carole Taliaferro
Prince George's County Dept.
of Family Services
6420 Allentown Road, Room 12
Camp Springs, MD 20748
301-265-8450
301-248-5362 FAX

Calvert County
Susan Hance
Calvert County Office on Aging
450 West Dares Beach Road
Prince Frederick, MD 20678
410-535-4606
410-535-1903 FAX

Carroll County
Cindy Howe
Carroll County Bureau of Aging
125 Stoner Avenue
410-386-3820
410-840-1968 FAX

Cecil County
Bob Dermott
Cecil County Dept. of Aging
214 North Street
Elkton, MD 21921
410-996-8438
410-996-5232 FAX

Charles County
Bonnie Hampton
Charles County Dept. of Community Svcs.
8190 Port Tobacco Road
Port Tobacco, MD 20677
301-934-9305 ext. 5145
301-934-0126 FAX

Queen Anne's County
Linda Carney
Queen Anne's Co. Dept. of Aging
104 Powell Street
Centreville, MD 21617
410-758-0848
410-758-4489 Fax

St. Mary's County Office on Aging
Rebecca Kessler
St. Mary's Co. Office on Aging
Garvey Senior Center
P.O. Box 653
Leonardtown, MD
301-475-4200, EXT. 1057
301-475-4503 Fax

Upper Shore Aging
Kathleen Garson
Waiver Unit Manager
Upper Shore Aging, Inc
100 Schauber Road
Chestertown, MD 21620
410-778-3817
410-778-3562 Fax

Frederick County
Dawn Day Morales
Frederick Co. Dept. of Aging
1440 Taney Avenue
Frederick, MD 21702
301-600-1657
301-600-3554 FAX

Garrett County
Kathleen Kitty Stuart
Garrett County Area Agency on Aging
104 E. Center Street
Oakland, MD 21550-1328
301-334-9431 ext. 138
301-334-8555 FAX

Harford County
Mark Carroll
Harford County Office on Aging
145 N. Hickory Avenue
Bel Air, MD 21014
410-638-3025
410-893-8239 FAX

Howard County
Phyllis Braxton
Howard Co. Office on Aging
6751 Columbia Gateway Drive
Columbia, MD 21046
410-313-6495
410-313-5970 FAX

Upper Shore Aging
Kathleen Garson
Waiver Unit Manager
Upper Shore Aging, Inc
100 Schauber Road
Chestertown, MD 21620
410-778-3621
410-778-3562 Fax

Washington County
Karin Escalante
Washington County
Commission on Aging
104 West Franklin Street
Hagerstown, MD 21740
240-420-2511